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HARVARD MEDICAL

ALUMNI BULLETIN / WINTER 1984 / VOL. 58 NO. 4

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INSIDE H.M.A.B.

In 1850 Oliver Wendell Holmes and the six other members of the Medical Faculty of Harvard University submitted an article to the American Medical Association, subsequently published in *The Boston Medical and Surgical Journal*, titled "Practical Views on Medical Education." In the first of 18 numbered comments they firmly observed, "Medical instruction should be adapted to the power of students to receive and retain what is communicated to them, and should be confined to what is important to them in their subsequent life." In number 16 they pointed out, "The longest lectures are of little use to students who want a common education, and whose medical education does not qualify them afterwards to observe, to inquire and to discriminate."

These views might as well have been contributions to the thinking that has gone into HMS's New Pathway Project in General Medical Education, an entirely new curriculum slated to start 135 years later, in 1985, for 25 entering students—members, appropriately, of the Oliver Wendell Holmes Society. In this issue, we report on the New Pathway with a several-part piece, including a letter from Dean Tosteson, a history of the planning process, a progress report, and a student's perspective.

In other school news, we introduce two new faces in Building A: Will Cochran '52, new Alumni Association director—who unwittingly wrote his own profile over the years in reunion reports for Harvard College and HMS—and Bill Stone, new dean for resources.

Three pieces in this issue touch on doctors and the experience of illness: Elissa Ely '87 muses in Student Forum on the line between cure and comfort; Deborah Zamcheck Atwood and Kimball Atwood '79 speak eloquently of their experience after an automobile struck Deborah, leaving her critically injured; and psychiatrist Edward Hallowell contributes an excerpt from a novel about the symbiosis of therapist and patient.

In a look at times gone by, HMAB editor and thoracic surgeon Gordon Scannell reports on little-known Sam Robinson, who in the early part of this century developed a positive pressure chamber at Massachusetts General Hospital that allowed surgeons to operate within the open chest of an anesthetized patient.

Finally, two pieces contemplate modern times: Rita Charon '78 shares her impressions of the New York hospital strike this past summer, and photojournalist Jerry Berndt chronicles life at Boston's Long Island Shelter for the Homeless.

— Lisa W. Drew

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Family Feeling

Internists in Primary Care

On Class Day 1984, a non-reunion year for me, I found myself in Boston and in the Quadrangle, hungry for an anamnestic surge of HMS family feeling as splendidly generated at our 25th, seven years ago. I wasn't disappointed. Reinforced by the prominence in alumni affairs of classmates Kay Clawson and Will Cochran, the relevance of our HMS experience to 1984 seemed clear.

However, I couldn't help feeling somewhat estranged after reading the Spring 1984 *Bulletin* on primary care at Harvard, which seemed to suggest that today's HMS is oblivious to its historic contribution to a principal source of primary care: the office-based internist. The *Bulletin's* individual stories were undeniably interesting, but why was the entire focus on hospital-based practice, subsidized HMOs, urban clinics, or almost romantically remote rural outposts?

As the American Society of Internal Medicine has had some success pointing out—at least away from Shattuck Street—quality primary care is and will be provided by internists in private practice. Many of them, like me, are proud graduates of HMS. Certainly there are maldistribution problems we cannot solve without some initiatives by medical schools and government, but the current belief, apparently pervasive at Harvard, that students can only choose between academe and the clinic is both depressing and incorrect.

Many of us have found the private, office-based practice of internal medicine, with or without a strong subspecialty interest, a personally satisfying and socially useful way of providing primary care. It would be a pity if this career choice is being lost

as a vigorous option at Harvard, and the loss would be particularly grievous if it were due to administrative failure to provide sufficient faculty role models from the host of happy front-line internists.

—James S. Bernstein '52

On Alumni Notes

The summer issue is even better than average, and that is a compliment. But I don't understand the breakdown of specialty choices among the Class of '84 on page 9. Why is poor old psychiatry down to six? And neurosurgery down to one! It seems appropriate that ophthalmology should be going up, but why only nine in primary care, in spite of the *Bulletin's* magnificent cover, the story by Robert Lawrence, and the candor of Suzanne Johannet?

The Alumni Notes are so *human*, some even super-human! Some of them are so nearly what I myself feel and might write that I almost look for my name to be signed! Others say they are retiring—kind of pathetic. But more write in to say they are *not* retiring (never will, I hope). They want us to know it, listing the things they are still doing. "I'm still a full-time professor," says one, not bragging, really: just wants us to know. Then it gives one a little pang, here and there, to read about illness—a stroke or a heart. Some almost apologize—"just limited consultations now," "a few appointments in the afternoon," "no long therapy cases; too much responsibility," "haven't quit teaching—*entirely*."

They seem obliged to try to encourage one another, bless their therapeutic hearts. But NONE admit that they have quit driving a car! (We should *brag*.) A few like to mention

Florida and Tucson and Europe; others talk about sons and daughters in practice or research—even in athletics!

What did Ulysses brag about in his old age? And how old was old then? Were there no mortals left around for him to run down and kill? And better, what did Hippocrates and Galen do when they got old?

—Karl Menninger '17

The editors welcome letters from readers, particularly in regard to articles published recently in the Harvard Medical Alumni Bulletin. Letters should be brief, double spaced, submitted in duplicate, and marked "for publication." Not all letters can be used; those accepted will become the property of the HMAB and may be edited, although we are unable to provide pre-publication proofs.

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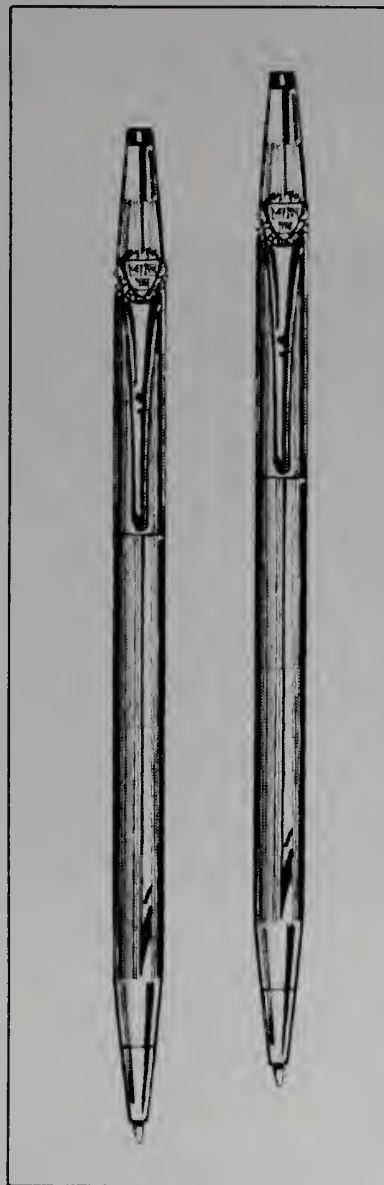
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Between Cure and Comfort

by Elissa Ely '87

Next fall my work on the hospital wards begins. Four years later, I should be a doctor. I wonder at times how this will be possible, for I am adept at ignoring unpleasantness, while doctors make a profession of involving themselves with illnesses that won't go away without intervention. Doctors enforce truth; they confirm what most patients suspect but yearn to ignore about their bodies. When my dentist doesn't find the cavity I know I have, he fails in his responsibility to make me acknowledge it. No matter how relieved I am, he has failed me. Negligence is when a doctor doesn't notice what a patient already knows.

Two years ago, before entering school, I volunteered on the patient floors of a cancer hospital. I filled water pitchers, dressed in a pink smock that divested me of the authority anyone might have wished to believe I had. Some of the patients were peremptory, some chatty, some kind—with a strange and extraordinary charm the very sick can show the healthy. One evening, I met an old woman, tiny like my grandmother, with ankles thick and dangling from the bed, just as my grandmother's do. I noticed how slowly she was eating, and asked about the dinner.

"It's good—for a healthy person," she said. She spoke very softly. "It's pea soup. That's good. But it's got salt. That's bad. I can't eat salt on account my stomach. But I don't like to complain here. They do enough. So—excuse me—I spit it out."

She looked at me through thick glasses. "It's a tumor started on my stomach," she said. "The doctors told my son now it's spread. Into the chest, and up into the lungs even a little." Her eyes, magnified by the lenses, were terribly large and clear. One foot

swayed in the space between bed and floor. "Not so bad, gotenyu, if you're already old," she said.

The arm that wasn't holding her fork was wrapped in a swaddling of warm towels. She pointed to it. "Three times to start those needles in my veins—except the needles didn't take. Now they got the head nurse to come and try. It's the chemical therapy. But I don't want a fourth time. It hurts. I don't like to complain. But look how big."

*The woman was asking
me to attend her pain—
to pay it court—
when I was unable to
alleviate it. No one could:
the chemicals were a
formality, the nurse a
source of discomfort,
the soup salty.*

I looked straight into her eyes; I couldn't bear to look down. "Look," she said. She pointed to her arm and I looked at her face. The room was hot. I wanted to edge toward the hall and the nursing station, where it was cool, and where the distance from her room was proportional to my distance from her pain. "Look," she said again, and finally I did; and to my shame and confusion, knew I was going to faint.

I cut her off in mid-sentence and backed out of the room. I remember the way her face collapsed.

How effective a physician is one who faints at her patient's pain? One of my uncles is a surgical oncologist in Dallas. When I told him what had happened, he said he understood it in one word: helplessness. "It was not the cancer itself that made you faint," he said. "It was your knowledge that you couldn't do anything to it. I don't faint around my patients because they need me to fight for them. Doctors get to fight."

I think maybe he was right. The line between cure and comfort is critical: when one is impossible, the other is still within reach. The woman was asking me to attend her pain—to pay it court—when I was unable to alleviate it. In fact, no one could: the chemicals were a formality, the head nurse a source of more discomfort, the soup salty.

There was a twilight period in my father's degeneration, a couple of months when he was too sick to work but not yet sick enough for final residency in some hospital. He lived at home, in bed and occasionally elsewhere. I remember one soft chair in the living room; most of the time it was empty, but every once in a while he would be very quiet and tired in the corner, somewhere in that chair. On those nights, my sister and I were asked—when we tried to find our favorite horse—not to punch, or bounce on his stomach, or scream in his ear. We never did, either, and now our restraint seems to me the closest we came to understanding our love.

We had a family doctor who oversaw all of us, a man with whom my parents socialized peripherally. He stitched and dosed us, pierced ears and wrapped sprains, knocked on knees, knew our glands intimately, and once came out to the car to vac-

ciate me after I had ragingly locked myself in. It was always a relief to be done with him.

Dr. X had examined my father when the first spot appeared on a lung X-ray; it was he who quietly suggested the first specialist, and he who followed the medical progress, deciphering for my mother the diagnostic and increasingly fatalistic lingo. During my father's twilight, he came every day—twice a day—with injections. Months he came. Months.

Several weeks after my father died, the doctor left a note in our mailbox. The note was simple. It said that he realized my mother's life had become financially as well as emotionally tangled, and that she should not worry about his bill until her resources and her strength had returned to her.

Doctors get to fight. When they aren't fighting, and they know how to, they get to comfort. Dr. X did both. He served as a traditional physician at first, and when cure was no longer a possibility, made the transition to comforter. In this second role, he kept life as painless as possible for my father while he lived, and for my mother after he died.

It seems to me that there are two responses to death: a first powerful lobby of fear and revulsion; and beneath it, an intact sense of gratitude and relief—because at last the body has closed its doors to pain. I don't know, myself, how to push past the fear and the helplessness. I don't think the answer lies in ceremonially exchanging a pink smock for a white robe. Somehow it has to do with a courage—acquired or innate, I don't know—but a courage like Dr. X's that is the opposite of negligence, and that says, firmly: here is the truth; we must live here. □

Before she came to HMS, Elissa Ely spent four years as a freelance writer. She recently published an article in Boston Magazine, titled "Diary of a Doctor-to-Be."

PULSE



Update on McLean

In a second effort to establish bonds with McLean Hospital, Hospital Corporation of America (HCA), a private international hospital chain, has submitted a proposal to lease, rather than buy, McLean. Last year an HCA proposal to purchase the institution was turned down after an HMS faculty committee advised against it (reported in the Spring 1984 *Bulletin*). Though the committee's report acknowledged the various benefits of the proposed sale, it also recognized that many faculty members felt "a close relationship between Harvard and a for-profit health-care provider to be wrong because it would tend to sustain penetration of the health-care system by investor-owned companies," and that the operation of teaching hospitals "should not be influenced by the

motivation for profit."

The new proposal is designed to meet many of those objections. McLean would continue to be owned by McLean Hospital Corporation (an affiliate of MGH), retaining its current governance structure and nonprofit status—and would receive much-needed renovation funds of \$35 million in addition to an annual "lease fee." HCA would lease McLean for an initial period of 20 to 25 years. The McLean Board of Trustees could terminate the lease on 90 days' notice, with or without cause, at any time. McLean would be obliged to repay, over time, only the unamortized amount of leasehold improvement costs. Two of McLean's trustees would be selected by HCA.

McLean faculty and staff were presented with the new proposal this summer. "The response of the Har-

vard faculty at McLean," said McLean general director Francis de Marneffe, quoted in the *Harvard University Gazette*, "has been very different than it was to last year's proposal." He attributed the change to several factors, including the many differences between the two proposals, and the open discussion over the past 10 months between staff and faculty, administration and trustees. In a memo distributed to the McLean community, McLean board chairman Francis H. Burr wrote that it would be difficult for the hospital to raise the necessary funds through conventional means of borrowing and fund raising, and that "an attempt to continue the status quo would in all probability lead to great misfortune."

The advantages to HCA of the arrangement would be the addition of the strength and prestige of HMS, MGH, and McLean to the HCA psychiatric services. HCA now owns over 400 hospitals, 28 of which are psychiatric institutions. □

Leaders in American Medicine

This year's Leaders in American Medicine series at Countway Library features five men well known to the HMS community, three of whom are graduates of the school. The multi-institutional combined film and discussion series, established in 1974 by George E. Gifford Jr., annually highlights the careers and contributions of outstanding physicians and dentists. Already this year the program has celebrated the work of Samuel H. Proger and Lloyd E. Hawes '37. It continues with programs devoted to James M. Dunning, Claude E. Welch '32, and Francis D. Moore '39.

The next session, which will convene on January 23, will focus on James M. Dunning, professor of ecological dentistry emeritus at Harvard School of Dental Medicine. During Dunning's tenure as dean from 1947 to 1952, HSDM was awarded full accreditation by the Council on Dental Education of the American Dental Association. From 1955 to 1965 he was director of the University Dental Health Service in Cambridge. His book *Principles of Dental Public Health*, published in 1962, is considered a standard text in its field.

Participants for this session include Myron Alukian, of the Boston De-



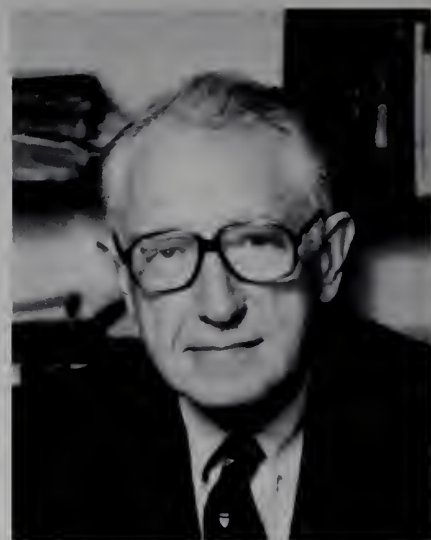
Claude Welch

partment of Health and Hospitals; Anthony Jong, associate dean for academic affairs at Boston University School of Graduate Dentistry; and James H. Shaw, professor of nutrition at HSDM.

The session on March 13 will feature Claude E. Welch, clinical professor of surgery emeritus at HMS. An internationally recognized authority on abdominal surgery with a specialty in gastrointestinal disease and cancer, Welch is senior surgeon at Massachusetts General Hospital, where he has been on the staff for many years. He holds the highest honor of the American Medical Association—the Distinguished Service Award—and is past president of the American College of Surgeons, the American Surgical Association, and the Massachusetts Medical Society. He is author of *Surgery of the Stomach and Duodenum*, which has been translated into several languages, and has written several hundred articles on gastrointestinal diseases and cancer.

Three HMS professors will be discussants for the program: Arnold S. Relman, professor of medicine and editor of the *New England Journal of Medicine*; George S. Richardson, associate professor of surgery; and Paul S. Russell, John Homans Professor of Surgery.

Concluding this year's series will be a program on April 10 devoted to Francis D. Moore, Moseley Professor of Surgery Emeritus at HMS. A distinguished surgeon, Moore is perhaps best known for his investigative work involving the use of radioactive

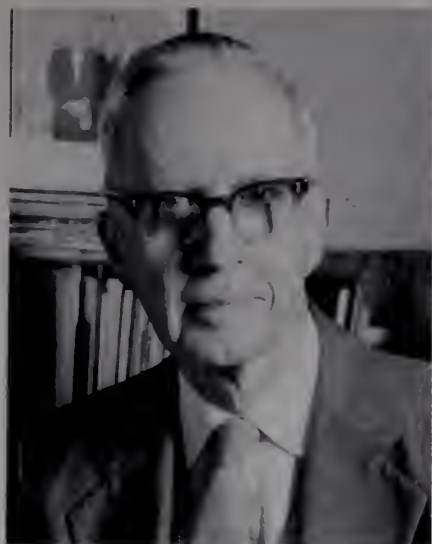


Francis Moore

isotopes in metabolic studies in surgery, which resulted in improvements in basic surgical care. He has been affiliated with HMS throughout his long career, and has received numerous awards and honorary degrees. He was Moseley Professor of Surgery and surgeon-in-chief of Peter Bent Brigham Hospital from 1948 to 1976, and Elliot Carr Cutler Professor of Surgery from 1976 to 1980. Moore was president of the American Surgical Association in 1972 and received its Samuel D. Gross Medal in 1978. In 1973 he was awarded the Bigelow medal of the Boston Surgical Society, and he received an honorary degree at the HMS Bicentennial Convocation. He is editor of the book review section of the *New England Journal of Medicine*, president of the Massachusetts Health Data Consortium, and author of many articles in his field.

Participating in the program will be Martin C. Moore-Ede, associate professor of physiology at HMS; David C. Sabiston, James B. Duke Professor of Surgery at Duke University; and Richard E. Wilson, professor of surgery at HMS.

The late Samuel H. Proger, chairman of the Department of Medicine at Tufts University School of Medicine, was the subject of the series' first program, held October 3. Proger, who died this past May at the age of 78, was chairman of the Tufts department from 1948 to 1971, and president and physician-in-chief of New England Medical Center. As a result of his guidance, NEMC, which consisted of 20 beds in 1930, is today transformed into a 452-bed teaching



Lloyd Hawes

hospital center with 25 buildings located in downtown Boston. In the process of expanding the center, Proger was responsible for geographically linking the medical and dental schools. Noted for his research in cardiology, he was first to describe the connection between salt intake and congestive heart failure. He was also able to demonstrate the positive results of exercise for patients with angina pectoris, and has been described by colleagues and friends as "one of the outstanding physicians, philosophers, and innovators in medicine for the past 50 years."

Discussants for this session were Marshall M. Kaplan, professor of medicine; Jerome P. Kassirer, professor of medicine; and Sheldon M. Wolff, professor and chairman of the Department of Medicine, all at Tufts University.

November 7 saw a program devoted to Lloyd E. Hawes, professor of radiology emeritus at University of Massachusetts and former radiologist-in-chief of Peter Bent Brigham Hospital. Hawes has been cited for his research on radiology as related to GI disorders. He was a former lecturer on radiology at HMS, and former member of the staff at both Tufts and Boston University schools of medicine. An expert on the history of radiology, Hawes assembled the nation's largest historical collection of radiological literature and equipment and presented it to Countway Library in 1969. The collection consists of over 1,000 books, early x-ray catalogs, reports, autographed papers, and equipment from the late 1800's to

modern times. Hawes was named honorary curator of the Historical Collection in Radiology at Countway Library, and has also served as historian of the New England Roentgen Ray Society. He is an international authority on antique ceramics, in particular Wedgwood.

Discussants for this program were Reginald Greene, associate radiologist-in-chief of Massachusetts General Hospital; Marjorie J. Lemay, associate professor of radiology at HMS; and Wladimir Zezulin, staff radiologist at the Lahey Clinic.

Leaders in American Medicine is run under the joint auspices of Leroy D. Vandam, M.D.; Mark D. Altschule '32; J. Worth Estes, M.D.; Richard J. Wolfe; and Mrs. George E. Gifford Jr. The program is sponsored by Boston University School of Medicine, the Benjamin Waterhouse Medical History Society, Boston Medical Library, Brown University Program in Medicine, HMS, and Tufts University School of Medicine—and is made possible by a grant to Boston Medical Library by Smith, Kline, and French Laboratories. All programs take place on Wednesday afternoons at 4:30, in Countway Library. Refreshments are served one half-hour before each program. □

Making the Grade

One left China four years ago; one came from Vietnam. One had been a junior champion tennis player; another had entered national ice skating competitions. One was an architect who had served in the Navy. Several had worked in the Peace Corps. They represent 28 states and four foreign countries, and include alumni of 63 colleges. All in all, the 166 members of the entering Class of '88 form a remarkably diverse group.

Perhaps the most striking statistic about the class is the number of women—75, or 45 percent—the highest in HMS history. In addition, the number of black students has grown from 10 last year to 18 this year—the highest in three years. This increase came about because more black applicants, once accepted to HMS, chose to enroll. Gerald Foster '51, director of admissions, credits the welcoming atmosphere created by the Committee on Admissions and the efforts of our current students who

participated in the admissions process, conducted tours, and were most hospitable to interviewed and accepted applicants.

The Class of '88 is also the first in recent years in which the greatest number do *not* come from New York State. That honor belongs to California, which produced 32 members. New York came in a close second with 30, and Massachusetts trailed with 24. Harvard led the colleges with 36 members. Princeton and Stanford tied with 10 apiece, followed by 9 from Yale. Alumni and faculty offspring account for 15 class members.

Also noteworthy was a growing trend in the interview process: more applicants took advantage of the regional interviews in San Francisco, Chicago, Atlanta, and Austin, Texas.

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These interviews, in which each student is interviewed by an admissions committee member and an HMS graduate who lives nearby, involved a greater number of alumni.

Foster is particularly pleased that an increasing number of accepted applicants are taking advantage of the deferred enrollment option. These students will spend this year undertaking projects that are personally or intellectually rewarding. They will return next year to enrich the Class of '89. □

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Ellore, SC (Emory)

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New Brighton, MN (Williams)

Ecker, Jeffrey L.
Elkins Park, PA (Princeton)

Emond, Stephen D.
Auburn, ME (Boston College)

Epstein, Jonathan A.
Brookline, MA (Harvard)

Ewing, Andrea D.
Columbus, OH (Brown)

Faghih, Katayoun
Stone Mountain, GA (Duke)

Farmer, Paul E., Jr.
Brooksville, FL (Duke)



Fishman, Martha P.
 West Newton, MA (Yale)
Forbes, J. Randall
 Auburn, CA (Stanford)
Fountain, Tamara R.
 Edina, MN (Stanford)
Franklin, Nancy E.
 Los Angeles, CA (Wesleyan)
Fried, Terri R.
 Great Neck, NY (Harvard)
Frim, Sara R.
 Newton, MA (Barnard)
Gochberg, Jan L.
 Newton, MA (Yale)
Gonzalez, Victor H.
 Huntington Park, CA (Princeton)
Goodman, Daniel W.
 Tenafly, NJ (Yale)
Goodman, Miriam C.
 North Haven, CT (Harvard)
Gordon, Wendy J.
 Wellesley Hills, MA (Harvard)
Gottdenker, Robin A.
 Woodcliff Lake, NJ (Amherst)
Graubert, Timothy A.
 Manhasset, NY (Dartmouth)
Hibberd, Mark G.
 London, England (University College,
 London)
Hoube, Jill S.
 Watertown, CT (Birmingham-Southern
 College)
Huttenlocher, Anna
 Chicago, IL (Oberlin)
Hwang, Sam T.
 O'Fallon, MO (Harvard)
Jain, Ahamindra
 Flushing, NY (MIT)
Johnson, Lise C.
 Staten Island, NY (Brown)
Karahalis, Stephanie
 Peabody, MA (Northeastern)
Kavadi, Vivek S.
 Houston, TX (Rice)
Key, Phillip S.
 Canoga Park, CA (UC Irvine)
King, Caleb K.
 Chapel Hill, NC (U. of NC at Chapel Hill)
Kinnane, Janet M.
 Swansea, MA (Mount Holyoke)
Konrad, Joan L.
 Philadelphia, PA (Kutztown State
 College)
Kuhlman, Jeffrey R.
 Saddle River, NJ (Harvard)
Kujovich, Jody L.
 Gettysburg, PA (Amherst)
Lara, Maria E.
 Guayanbo, Puerto Rico (MIT)
Larson, Richard S.
 Wilmington, NC (U. of NC at Chapel
 Hill)

April 13, 1984

Dear Director of Admissions,

I am 8 years old and want to be a pediatrician so I am writing to you. I would like to go to Harvard Medical School.

Should I read lots of books? Why don't doctors get sick from treating sick patients? Do you ever have courses for children? What would I have to do to be able to get in?

Please send me information on Harvard Medical School.

Sincerely,
 Alexandra Drinstein

From the mailbox of the director of admissions

Lee, Maxine M. Bridgeport, CT (Fairfield)	Markowitz, Steven M. Searsdale, NY (Harvard)
Lee, Raymond Cranston, RI (MIT)	Masterson, Brian J. Galesburg, IL (U.S. Air Force Academy)
Lentz, Daniel Rancho Cordova, CA (UC Davis)	Mayer, Ellen L. Miami, FL (Cornell)
Leong, Rebecca J. Orinda, CA (Brandeis)	McCarthy, Claire Merion, PA (Princeton)
Levy, Joanne E. Searsdale, NY (Yale)	McIntyre, James E. Staten Island, NY (Columbia)
Licini, Raymond P., Jr. Los Angeles, CA (U. of Southern California)	Mercado, Williefred E. Jamaica, NY (Queens College of The City University of New York)
Lowy, Adam E. Great Falls, VA (Harvard)	Meyer, Jonathan M. Northridge, CA (Stanford)
Lozano, Paul A. El Paso, TX (U. of Texas at El Paso)	Mildrow, Warren K. Neptune, NJ (Cornell)
Mai, Christopher H. Sunnyvale, CA (Stanford)	Nguyen, Mai H. Irvine, CA (UC Irvine)
Margolis, Thomas I. Uniontown, PA (U. of Pennsylvania)	Nuss, Roger C. Huntington Valley, PA (Swarthmore)

Oettinger, Marjorie A.
Belmont, MA (Harvard)

Okada, Annabelle A.
Honolulu, HI (Harvard)

Olans, Lori B.
Peabody, MA (Harvard)

Ozuna, Richard M.
Arcadia, CA (Pepperdine)

Phillips, Preston J.
Atlanta, GA (Emory)

Potrebic, Sonja B.
Allentown, PA (U. of Pennsylvania)

Priebe, Cedric J., III
Oldfield, NY (Harvard)

Rak, Ellen M.
Farmington, CT (U. of NC at Chapel Hill)

Regillo, Carl D.
Lexington, MA (Northeastern)

Retondo, Margaret J.
Portland, OR (Bowdoin)

Richardson, William S.
Brookline, MA (Tulane)

Rogers, Campbell D. K.
Winchester, MA (Harvard)

Rosenfeld, Howard M.
Narbarth, PA (Harvard)

Ryan, Edward T.
New York, NY (Princeton)

Sadler, Karen L.,
Colonia, NJ (Brown)

Salob, Stacy P.
East Hills, NY (U. of Pennsylvania)

Schiff, David
Chicago, IL (Harvard)

Senecek, David R.
Gulf Breeze, FL (U.S. Air Force Academy)

Shainfarber, Linda H.
West Hartford, CT (Brandeis)

Short, Letitia W.
Baltimore, MD (Carnegie Mellon)

Shrager, Joseph B.
Newtown Square, PA (Amherst)

Silk, Adam J.
Montclair, NJ (Harvard)

Sonner, James M.
Upland, CA (Harvey Mudd College)

Stack, Anne M.
Cazenovia, NY (Colgate)

Sussman, Stephen A.
Studio City, CA (UC San Diego)

Sylvestre, Diana L.
Kissimmee, FL (U. of Florida)

Tan, Swee L.
Kuala Lumpur, Malaysia (Bryn Mawr)

Taub, Ethan
New Haven, CT (Harvard)

Teach, Stephen J.
Buffalo, NY (Yale)

Terrell, Jeffrey E.
Silver Spring, MD (U. of Chicago)

Thompson, Rupert A.
Brooklyn, NY (U. of the West Indies)

Thorup, Steven J.
Pleasant Hill, CA (UC Davis)

Toxey, Julia F.
Arlington, TX (U. of Texas at Austin)

Underberg, Sharon J.
Hastings-on-Hudson, NY (Swarthmore)

Urioste, Debbie D.
CO Springs, CO (Colorado College)

von Deck, Mercedes D.
Hopkinton, MA (Washington U.)

Waldman, Barry A.
Massapequa Park, NY (U. of Pennsylvania)

Wang, Phillip S-E
Rossevelt Island, NY (Harvard)

Waterhouse, Elizabeth J.
Washington, DC (Harvard)

Watson, Karol E.
Cypress, CA (Stanford)

Weston, Lynn A.
San Diego, CA (Princeton)

White, Linda D.
Philadelphia, PA (Harvard)

Wilson, Fiona C.
Saratoga, CA (UC Santa Cruz)

Wilson, Kim A.
Syracuse, NY (Middlebury)

Wilson, Madeline S.
Holden, MA (Harvard)

Wilson, Robert H.
Columbia, SC (Johns Hopkins)

Wilson, Stephen D.
Berkeley, CA (UC Berkeley)

Wong, Samuel T. T.
Agincourt, Ontario, Canada (Harvard)

Wu, Thomas D.
San Jose, CA (Stanford)

Yien, Karin N.
Santa Cruz, CA (Mills College)

Young, Alexander S.
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Information and application forms may be obtained from:

Committee on Alumni Fellowships
Harvard Medical School
Room 414, Building A
25 Shattuck Street, Boston, MA 02115



A NEW PATHWAY FOR GENERAL MEDICAL EDUCATION



PHOTOS BY JERRY BERNDT

Steering Committee and staff. Standing, left to right: Myra Ramos; Eleanor McLaughlin, NP curriculum coordinator; Charles Richardson; S. James Adelstein '53; Susan Carver, NP assistant director for program support; Harvey Goldman; Herbert (Skip) Virgin '85; Gordon Moore '63, NP director; Daniel Federman '53; Paul Unger '86. Seated: LuAnn Wilkerson, NP director of faculty development; Philip Leder '60; William Silen; Dean Daniel Tosteson '48, chairman; Leon Eisenberg; Mary Jo Litchard, NP administrative assistant; C. Roland Christensen. Not shown: Susan Block, NP case development coordinator; M. Judah Folkman '57, co-chairman; John Potts; Henry Rosowsky.

Next fall, 25 students out of the entering Class of 1989 at HMS will enter the Oliver Wendell Holmes Society, the first step toward developing the New Pathway Project in General Medical Education and an initiative that, Harvard University president Derek Bok has written, "may well turn out to be Harvard's most impressive innovation of the 1980s." From their earliest days of medical school, the members of the Holmes Society will practice seeking out information, testing hypotheses, and solving problems in a process similar to that of experienced clinicians and researchers. The approach will be a pioneer foray into the extensive use of such learning through the full four years of medical school, for both the clinical *and* basic sciences, to prepare students for advanced study in any special field of medicine or research.

Within their first two weeks the Holmes Society students will see patients; within a month they will have contracted with a preceptor (a faculty member) with whom they will follow ambulatory patients for as long as the next four years. They will meet several times a week for problem-based learning tutorials, and will have ongoing, personal contact with Holmes Society faculty members. Sixty percent of their time will be devoted to a common Holmes Society curriculum that will include no more than one lecture a day. The remainder of their time will be available for elective courses and independent study leading to a thesis. Computers will be important learning and reference tools.

The New Pathway faculty members will serve as guides or resources rather than lecturers. Their task will be to raise questions more than convey information—and to integrate psychosocial and ethical issues along with clinical and basic science learning.

To report on the new curriculum, the *Bulletin* has drawn on several sources: on the pages that follow are a letter to alumni from Dean Tosteson, a brief history of the planning process, an abbreviated and updated version of the progress report approved by the Curriculum Committee in May 1984, and a report from a student taking a year off to help design the new curriculum. Although the basic goals of the Holmes Society are firmly established, the curriculum itself is subject to much revision before its implementation next fall; none of the specifics on the following pages are carved in stone.

LETTER TO ALUMNI FROM THE DEAN

The Harvard Medical School has begun to move along a New Pathway toward general medical education. I am pleased that this issue of the *Bulletin* contains articles that bring the alumni up to date on this movement. An important early step along this New Pathway is the formation of the Oliver Wendell Holmes Society, which will matriculate 25 students annually beginning in the fall of 1985. I strongly encourage all members of the HMS family—faculty, students, and alumni—to join this New Pathway, because I think that general medical education is a serious and complex set of issues that deserves more sustained and coherent attention than it now receives in our community.

Many thoughtful observers of academic medicine have recently come to similar conclusions. A study of the Institute of Medicine on Medical Education and Societal Needs and the panel appointed by the Association of American Medical Colleges (AAMC) to consider the General Professional Education of Physicians (GPEP) both urge more vigorous work by medical faculties to adapt general medical education to the increasingly rapid changes in medical science and practice. In his most recent annual report, President Bok urged the Faculty of Medicine at Harvard to address these issues. These recommendations resonate with many of the suggestions made in the report of a Commission of the AAMC chaired by President Lowell in 1932. Indeed, a comparison of these analyses put forward more than 50 years apart raises the question of why the problems of general medical education are so intractable.

I think that there are at least two sets of reasons. First, medical schools, including Harvard, are not well organized to carry out general medical education. Second, the issues are complex

and conceptually difficult. Let me be more specific.

The members of the Faculty of Medicine at Harvard serve society in several important ways. Most of their effort is directed to medical research, toward making the fundamental discoveries that will inform the medicine of tomorrow. The next largest component goes toward caring for patients, largely in various subspecialty services, in the teaching hospitals. The remaining effort is given to educational programs. Of this, more than half is concentrated on the education of practicing physicians (continuing education), residents in various clinical specialties, and graduate students in the basic medical sciences. Less than half of faculty educational effort is allocated to programs directed toward preparing students for general doctoral degrees: the D.M.D. through the School of Dental Medicine and the M.D. through the Medical School.

All these forms of service are important. I believe that Harvard should continue to work as creatively and effectively as possible in research and specialty training in the clinical and basic sciences. Moreover, the present departmental and divisional structure of the Faculty of Medicine and the pattern of reimbursement for research and patient care are well suited to support these programs. Unfortunately, the present system of organization is not as well configured to sustain coherent and integrated planning and presentation of the curriculum leading to the M.D. degree.

Responsibility for each course rests with a department; close coordination between courses is difficult to arrange. Educational strategies aimed at the development of attitudes and skills that transcend individual courses are insufficiently considered. One goal of the New Pathway is to make and test organizational structures that promote greater coordina-

tion and integration of general medical education. The Oliver Wendell Holmes Society is one such structure, designed to bring together a small group of faculty members charged with the responsibility for the entire span of experiences leading to the M.D. degree.

The idea of general medical education—the attitudes, skills, and knowledge that all doctors should share—is complex and difficult. The criteria for selection of material to be included are not as clear as they are in programs of specialty training. The pressure for adding new subjects intensifies as the pace of discovery accelerates. The symbiosis between medicine and the biological and physical sciences becomes closer and more fruitful, demanding new ways of strengthening the representation of science in general medical education. At the same time, concern mounts about the loss of breadth, for increased attention to the social sciences and humanities, to ethical issues in medicine, to all of the factors thought to be important in the genesis of a physician who is not only competent technically but who cares for and about each patient. Another goal of the New Pathway is to think seriously about and devise approaches to these and other difficult unresolved and conceptual issues in general medical education.

I do not imagine the New Pathway as a turnpike to a city, but rather as a direction and a way of moving. An effective pattern of general medical education is not a place to be reached but a set of issues to be worked. I hope that the New Pathway provides opportunities for more members of our faculty to work more creatively and intensely on general medical education.

—Daniel C. Tosteson

A BRIEF HISTORY

Formally created in June 1984, the New Pathway has been in the making since an intensive brainstorming retreat at Pine Manor College in May 1982. It was the fourth in an annual series of such workshops, created to consider the pressures and needs of medical educators and students. Titled "A New Approach to Medical Education," the day featured a presentation by Dean Tosteson proposing the experimental curriculum, and panel and group discussions among roughly 100 HMS faculty, students, and administrators. Tosteson then convened a 20-member planning group of students, faculty, and administrators to "think, from the ground up, about the essential ingredients of medical education."

In early 1983, the 20-member New Pathway Planning Group organized three working groups, 15 to 20 members each, called Attitudes, Skills, and Knowledge. Their task: to consider and report on the central goals of the New Pathway.

In June 1983 the Faculty of Medicine and Curriculum Committee approved a report of the New Pathway Planning Group, giving a green light for initial steps in designing the new curriculum for its implementation in the fall of 1985. The report had also been endorsed by the Faculty Council.

As the work proceeded, several key features of the new curriculum emerged:

- Equal emphasis on attitudes, skills, and knowledge.
- Careful selection of essential knowledge, to avoid information overload.
- The perspective of a single faculty looking at the entire span of general medical education rather than discrete, separately planned curriculum components.
- Close student-faculty contact.

- Interweaving of clinical and basic science elements throughout curriculum.

- Use of active educational methods such as problem-solving and information management.

- An environment in which students and faculty learn together.

- An opportunity to pursue a topic in depth, leading to a thesis.

- Emphasis on skills enabling students to become lifelong learners.

One of the ideas from the Pine Manor retreat that drew much attention was a seven-year plan for the New Pathway, with admission to medical school in the junior year of college. The HMS community's reaction was immediate and intense, and for a time eclipsed the ongoing fundamental rethinking of medical education. Debates raged over the pros and cons of early admission.

Over the following months, inclusion of the college years was postponed—although President Bok asked the HMS faculty not to abandon the idea. "Premedical requirements have a major distorting effect on undergraduate education, cramping the breadth of the student's curriculum," he said at the June 1983 Faculty of Medicine meeting. "The university is at its best when it takes on difficult, longstanding problems. . . . This problem calls out for creative improvement and solution."

Currently there are ongoing discussions between representatives of the faculties of HMS and Harvard College to review the current undergraduate premedical program and consider possible revisions.

It was also recommended in the June 1983 report that the Planning Committee explore the possibility of developing a special first post-graduate year experience for New Pathway

students. That idea is still under discussion.

At intensive workshops in July and September 1983, a working structure evolved, including a Steering Committee (successor to the Planning Group), chaired by Dean Tosteson; eight Curricular Design Groups (CDGs) charged with creating specific yet interlocking segments; a Curriculum Coordinating Committee (now the Core Planning Group), consisting largely of CDG chairpeople; and support committees to develop such areas as information technology, faculty development, and program evaluation.

The Steering Committee membership includes such diverse backgrounds as those of C. Roland Christensen of Harvard Business School; Henry Rosovsky, dean of the Harvard Faculty of Arts and Sciences; and chairmen of three HMS departments: Phil Leder (Genetics), Charles Richardson (Biological Chemistry), and Leon Eisenberg (Social Medicine and Health Policy).

There are now seven CDGs, defined and chaired as follows:

- Doctor/Patient: Robert Lawrence, chairman of the Dept. of Medicine, Cambridge Hospital
- Human Biology I (structure and function of the body): Daniel Goodenough, Dept. of Anatomy, HMS
- Human Biology II (identity and defense): Robert Colvin, Dept. of Pathology, MGH
- Human Biology III (information processing and behavior): Edwin Furshpan, Dept. of Neurobiology, HMS
- Human Biology IV (metabolism of matter and energy): Martin Kushman, Dept. of Radiology, BWH

- Life Cycle: Robert Masland, Pediatrics, Children's Hospital
- Experiences in patient care: Daniel Federman, dean for Students and Alumni

In May 1984 the Medical Curriculum Committee endorsed a 68-page progress report on the experimental curriculum. That approval led to the formal establishment in June of the Holmes Society, with Gordon Moore '63 as director of the New Pathway Project. A shortened and updated version of the report appears on the following pages.

With less than a year left, the Steering Committee now meets monthly; the Core Planning Group meets weekly for an intensive afternoon session; faculty development programs are underway; and the admissions material for the school has informed applicants of the new opportunity.

Students in the entering class will be given the opportunity to volunteer for the New Pathway. If more than 25 express interest, the final group will be drawn from a random stratified sampling; sex and minority status will be taken into consideration.



In a parallel effort to the New Pathway, the Association of American Medical Colleges, with the support of the Kaiser Family Foundation, recently culminated a three-year national appraisal of medical education with a 48-page report. Titled *Physicians for the Twenty-First Century: The GPEP Report* (Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine), the study reads like a blueprint for the New Pathway. Among its recommendations are problem-based learning, improved communication between

students and faculty, use of computer technology, limits on required memorization, and broadened undergraduate preparation.

Among the innovations taking place at other medical schools:

- McMaster University was one of the early pioneers in problem-based learning. It offers a three-year M.D. program emphasizing problem solving in small tutorials during the first two years.
- The University of New Mexico Medical School has developed a separate Primary Care Curriculum modeled on the problem-based program at McMaster, with the addition of a four-month rural preceptorship between the first and second years.
- Boston University School of Medicine offers six different pathways to a medical degree, ranging from the traditional four years to a six-year medical degree course program accepting students straight from high school.
- Johns Hopkins has a Flex-Med program which allows students options about when to enter.
- At Michigan State, a number of medical students are pursuing an independent study program.
- Brown University will begin a seven- or eight year continuum, which will accept students after their senior year of high school. The program, which eliminates all pre-med requirements, allows students to take both traditional undergraduate courses and medical courses throughout their years of study.
- Southern Illinois University School of Medicine has applied an objectives-based approach to its entire four-year curriculum. It is currently attempting to systematize a number of formats for problem-based learning.

Planning for the Oliver Wendell Holmes Society is still under way, with many fine points yet to be decided. The following is a shortened and updated version of the latest progress report, submitted to the Curriculum Committee in May 1984. Many of the details will change as planning continues.

Changes in medical education stem from changes in medicine and in the society physicians serve. In the 1980s, change is perhaps more dramatically apparent in medicine than in any other professional sector of American society. Within the last decades, scientific and technological discoveries have profoundly altered medical knowledge, leading to entirely new understandings of the human being in health and disease. Recent advances, particularly in molecular and cell biology, immunology, and neurobiology, have opened new paths to preventive, diagnostic, and curative strategies of astonishing power and subtlety.

As the fraction of the total spectrum of knowledge that can be mastered by a single individual has diminished, the number of specialties has grown, yielding an increasingly fragmented medical practice. The many new applications of technology to medicine, while greatly enhancing diagnostic and therapeutic power, have introduced a new contradiction for practitioners between their role as expert technologists on the one hand, and as counselors and guides on the other.

No less challenging are the many changes originating outside of medicine. Demands for cost containment, and the resultant shift from reimbursement to prospective budgeting in hospitals, have so altered the economics of health care that medical

and financial incentives often conflict. The information sciences are providing new ways to solve old problems, thus reshaping how medicine is learned and practiced. An increasingly informed and concerned American public is asking physicians to create a more equal partnership with their patients, and to encourage patients to assume primary responsibility for their own health care and treatment.

Yet some aspects of the physician's relationship to the sick and suffering—such as the time-honored skills of caring and responsibility—remain constant. The experience of illness has always presented a vast array of intangible elements, and, despite the growing revolution in science and technology, physicians will continue to practice their art in the midst of uncertainty.

A general medical education should adequately prepare physicians for advanced study toward careers in any of the general or specialty fields of medicine, in academic research, administration, or teaching. The HMS faculty and students engaged in planning the Oliver Wendell Holmes Society seek to graduate physicians who are:

- equipped with a perspective on biological systems that is of sufficient breadth, depth, and flexibility to enable them to cope with a complex and rapidly changing world,
- committed to continuing to learn in medicine; able to acquire and use knowledge well and to use information-managing technologies,
- sensitive to the caring that underlies medicine; in touch with the personal side of doctoring; concerned about and responsive to moral and ethical issues.

Curriculum and Educational Methods

The New Pathway curriculum will be a continuum, interweaving the clinical and basic sciences, humanities, and social sciences bearing on medicine. There will be ongoing relationships among faculty and students, and ongoing assessment of students' professional development. Essential knowledge will be learned in concert with attitudes and skills and will, whenever possible, be captured in the form of problems or cases that will be worked by faculty and students together. The curriculum will offer both a common itinerary and opportunity for in-depth, individual exploration.

Educational methods will reinforce cooperative learning and collaboration, and will promote active learning, questioning, problem solving, and critical thinking. Problem-based tutorials will predominate. Five to eight students, working with a preceptor, will use problems to explore basic science, clinical, psychosocial, ethical, legal, economic, and personal issues. The preceptors will encourage students to determine what questions to ask, which research strategies to pursue, and how to acquire necessary information. Students will be responsible for gathering information and consulting with resource faculty.

Basic science learning will extend over the entire four years, with material from the four human biology design areas and the design groups on the patient, the doctor, and experiences in patient care integrated throughout the course of study.

During the first two years, learning will be largely shaped by studies in human biology, with relevant clinical experiences, issues pertaining to the doctor-patient relationship, and topics in the social sciences and humanities amplifying each topic. In years three and four, when hospital-based expe-

riences will predominate, exposure to basic science will continue. During clinical rotations, weekly tutorials will systematically explore basic science issues raised by the patients seen, and students will devote three separate month-long periods to pathophysiology and analysis of basic science problems raised by cases seen in previous clerkships.

Students will have contact with patients from the beginning of their first year. Starting with patient interviews, and progressing step-by-step through the fundamentals of history-taking and physical examination, they will see patients in a variety of settings, including ambulatory, in-patient, nursing home, and chronic care facilities, home visits, and social service settings. There will be no Intro-

With such extraordinary advances in scientific knowledge, not to mention the metamorphosis of the health care system and its attendant policy problems, one would have expected comparable changes in the shape and substance of medical education. In fact, such changes have occurred in the *content* of courses. Instructors have been quick to tuck the latest scientific findings into their classroom lectures and their discussions on hospital wards. But the *methods* and the *structure* of medical education have stayed surprisingly constant through the postwar period.

—Derek Bok, *The Present and the Future*, 1982-83.

duction to Clinical Medicine course in the New Pathway. Instead, clinical skills sessions using videotapes, programmed patients, and a variety of clinical settings will provide step-by-step progression through the fundamentals of history-taking, differential diagnosis, and, eventually, the full work-up and assessment of patients. These sessions will be led by a clinician with background in the human biology area under study, and will draw upon the expertise of resource faculty in the basic and clinical sciences as needed.

Each pair of students will work closely with a basic science tutor and a clinical preceptor over the entire four years, sharing clinical experiences linked to curriculum content areas. As part of the unit on the life cycle, students will follow patients throughout the four years of study, learning about their life history and what happens to them after medical treatment. They will observe a pregnant woman and her family through pregnancy, delivery, and the early development of the child; follow pa-

Faculty members should have the time and opportunity to establish a mentor relationship with individual students. The practice of having a large number of faculty members, each of whom spends a relatively short period of time with medical students, should be examined critically and probably abandoned.

— "Physicians for the Twenty-First Century: The GPEP Report," Association of American Medical Colleges, 1984.



Core Planning Group members LuAnn Wilkerson, Daniel Goodenough, Robert Colvin, Susan Block. More on page 22.

tients through ambulatory care and make periodic home visits; and follow an elderly patient through hospitalization and subsequent long-term care.

From the beginning of the first year, students will learn "doctoring" and reasoning skills, and will reflect on the implications of physician roles, historical changes affecting these roles, and changes during the life cycle of the individual physician. Principles of biostatistics, epidemiology, and cost-effectiveness analysis will be in-

troduced through sequenced clinical cases. Time will be devoted to exploration of the student's attitudes toward self, colleagues, family, and patients.

Further exploration of students' notions of what it is to be a physician will confirm and validate the attitudes that attract them to medicine. Small group discussions, an ongoing preceptorship, and participation in a support group with a trained leader will allow students to discuss their critical first experiences, such as the

examination of a patient, exposure to a cadaver, and the death of a patient. Also throughout the four years, weekly sessions on the patient-doctor relationship will provide students with a wide contextual understanding of the patient's experience, and of the structural, social, political, and economic aspects of practice.

Approximately 40 percent of the New Pathway curriculum will be reserved for individual experiences designed to meet the special educational goals of each student, under the guidance of an adviser-preceptor. Elective experiences may be individual, such as research, work-study projects, or home study courses; group activities, such as elective coursework at HMS, MIT, or Harvard University; courses specifically designed to meet the needs of Holmes Society students; or field work with an international, domestic, rural, or urban health project. Individual special projects will culminate in written theses.

As they enter the New Pathway, students will receive a Curriculum Content Guide, a workbook that will systematically outline, for each component of the curriculum, detailed knowledge objectives, study questions, educational resources, and readings for further study. It will serve as a resource for students seeking to fill in gaps in their knowledge, and as a first reference source. It will be electronically stored and updated annually.

A "signature" series of lectures by outstanding HMS faculty will illuminate, rather than cover completely, the topics systematically outlined in the Curriculum Content Guide. Lectures will be limited to no more than one per day, with a minimum of five given by each speaker.

Students will use computers to facilitate their learning in medicine. The New Pathway's computer system will be used for word processing,

database development and management, computer-assisted learning, and database and literature access. Electronic mail will enhance and ease communication among faculty and students. Evaluation methods will increasingly draw upon the interactive capability of the computer.

Evaluation

Evaluation of students will be based on the detailed statements of educational goals and objectives they will receive as they enter medical school and before each new unit of the curriculum. A faculty advisory network will closely monitor student progress, and will provide regular feedback to the student and his or her preceptor. Most evaluation will be "open book," personal, frequent, and informal. The preceptor will provide ongoing appraisal of the student's interpersonal, attitudinal, and skill development in a format that can be used as a basis for later reference letters.

A list of "guiding questions," with accompanying references and supporting materials, will direct the student to the key principles, concepts, and learning issues in each unit of the curriculum. Students will be evaluated for their general knowledge, problem-solving, and clinical reasoning abilities by their responses to a selected set of these "guiding questions." In addition, mastery of essential knowledge will be appraised by means of self-directed testing, and clinical competency will be tested using programmed patients, which allow valid cross-student comparisons and assessment of a single student's development over time.

Overall evaluation of the student will be competency-based. Students will be required to respond satisfactorily to a randomly selected, statistically significant sample of the total set of guiding questions. The student

may come to the Holmes Society teaching center (see Faculty Development below) at any time, and will be expected to respond within a generous but defined period. Graduation will require successful completion of this hurdle.

New Pathway students will take National Boards under the same policy as other HMS students. However, the Steering Committee strongly urges that a special HMS task force reexamine use of the boards for their appropriateness as a means of evaluating both the New Pathway and the existing curriculum.

Program evaluation (as distinct from student evaluation) will feed back to the faculty information about successes and failures so they may improve its design in future years. It will compare the educational methods in the Holmes Society with those of the standard curriculum by comparing the performance of students in

First and foremost, [academic medical centers] should turn the spotlight back on their only unique social purpose: the turning of young men and women into doctors. . . . More attention to the care and feeding of medical students, more rewards to faculty for paying attention to them, more concern with their attitudes toward science, the values they acquire, and the ways they approach the care of sick people *do* have public interest

— David Rogers, president of the Richard Wood Johnson Foundation, at the Symposium on the Future of Medical Education, HMS, June 1983

the two curricula on such factors as knowledge of basic science and scientific method, clinical problem solving ability, modes of self-learning and self-assessment, professional attitudes, and adaptive strategies for coping with stress. This evaluation will be used solely for the program and will not be part of students' academic record.

The overall strategy will employ a matched comparison group in the standard curriculum, selected either from among those volunteering for but not accepted into the New Pathway (if they are sufficient in number) or by composing a stratified sample. Participant observation techniques will be used to study individual activity and group process; diaries of time expenditure and critical incidents will be used to sample student behavior. Periodic interviews will be conducted with students in both groups to study the evolution of their concepts of competence and caring.

We seek to have the student learn by experience; to prove things for himself. The student cannot too early learn that medicine is not an exact science; that the accepted fact of to-day may be proved an error to-morrow; that his teacher and his chosen text-book cannot be followed implicitly; that he must search out the truth for himself.

— Richard C. Cabot and Edwin A. Locke, *Boston Medical and Surgical Journal*, 1905.



Core Planning Group members Robert Lawrence, Paul Unger, Charles Hatem, Susan Carver. Not shown on these pages: Gordon Moore, Octo Barnett, Daniel Federman, Ed Furshpan, Martin Kushmerick, Robert Masland, Eleanor McLaughlin.

Faculty Development

The New Pathway faculty will function in non-traditional teaching roles. As fellows of the Holmes Society, they will serve as tutors for small groups, act as resource people, and evaluate students' cognitive and affective growth. Even the role of lecturer will be different in the new curriculum, as lectures will provide a guiding and orienting framework for the problem discussions rather than transmitting a plethora of facts about a discrete subject. New Pathway faculty must also decide which concepts and information can be omitted, and understand as basic scientists what a practicing doctor needs to know.

Last January, Jeff Berman '85, then a research fellow for the New Pathway, developed and taught a course for first-year students to demonstrate problem-based learning. This year Paul Unger '86, who has succeeded Berman as research fellow, will present the course again, writing new

cases that will be used later in actual Holmes Society sessions. This year's course will also help train teachers in the problem-based method, serving as the basis for an initial series of faculty seminars, during which faculty will observe (via videotape and possibly one-way glass) a problem-based learning group in action. (See piece by Paul Unger below.)

Beginning in the spring of 1985, New Pathway faculty will be offered skill development workshops that actively involve participants in learning, with practice teaching with peer groups, videotaping and review, and simulations. Topics will include adult learning theory, leading a small group discussion, asking questions, determining learning objectives, providing feedback to learners, and methods of student evaluations. Retreats, intensive conferences, and informal discussion groups will be used as appropriate. Workshops will also be provided for students in the fall of 1985 to enhance their skills in learning in the

STUDENT PERSPECTIVE

by Paul Unger '86

problem-based, independent mode.

Plans are underway to establish a teaching center, similar to the Harvard Danforth Center for Teaching and Learning, to focus on the needs and special challenges faced by the Holmes Society faculty—and to offer a systematic process for assessing and improving teaching. The proposed center will stimulate ways of thinking about medical education, teaching methods and teaching materials, patterns and frequency of teacher/student interactions, and the status of teaching as a professional activity.

The center will offer four broad categories of faculty development activities: educational consultation, episodic programs, individualized teaching assessment, and instructional resources. The growth of the faculty member as an expert within his or her own discipline will continue to be the responsibility of the academic departments and of the faculty member.

A collection of resources about and for teaching—books, articles, journals, videotapes, and computerized self-instructional materials—is currently being developed for the New Pathway, and a study area is being designed. "Field experiences" will promote an interdisciplinary approach, so basic scientists and clinicians can benefit from each other's perspectives. The center will also attempt to build a cadre of "master" teachers, identified by peer or student nomination, who would allow colleagues to observe and discuss their teaching.

This material was compiled by the Bulletin staff, with the help of the New Pathway staff. The progress report, a condensed and updated version of which appears here, was originally written by Eleanor McLaughlin, curriculum coordinator of the New Pathway.

Unfortunately, I am too far into my medical education to apply to enter the first class of the Oliver Wendell Holmes Society in the fall of 1985. However, due to my experiences as a student at HMS, I have come to feel strongly that medical students ought to take responsibility for their own learning, and that students should participate in defining the body of knowledge to be mastered and the methods used to learn it.

I have been involved in the planning phases of the New Pathway ever since Dean Tosteson introduced his ideas to faculty and students in the spring of 1982. I have postponed my fourth year at HMS to spend this year as a research fellow for the Holmes Society, because it seemed crucial to me that students be intimately involved in helping define the program from the ground up.

During my first two years at HMS, as I sat in amphitheatres with my classmates and ghosts of alumni, trying desperately to "learn," I pondered how the material presented related to practicing medicine. What level of detail was required if one was to be a good doctor? Was memorizing tables and biochemical pathways crucial to my success in medicine? Where were the patients? I was not alone; the entire class seemed to lack perspective on how our daily studies were important to our ultimate patient responsibilities. Our teachers made vague attempts to "illustrate" these points, but fell far short of integrating basic science with clinical medicine. This gap in my understanding remained until I was a third-year student confronted by clinical problems on the wards.



It was my first morning on a medical ward service, with the concomitant first session of "Visit Rounds"

—medical students' daily teaching session with a senior faculty member. Each new rotation had brought with it a new teaching format, a different style and set of educational objectives, at the whim of the instructor. What would be expected this time? Would this be another chance to recite the text memorized last night from

What reforms do you think are necessary to improve medical education?

- More emphasis on ethics, health policy, community work
- More early clinical teaching
- Encourage thinking: cases, problem solving
- More individualized or small group instruction
- Cut down on detail
—more on what's important
- Less pressure in clinical years and residency
- Better role models
- Fewer large lectures
- Require or encourage time off before medical school
- Reward good teaching
- More flexible early admissions
- Fewer science premed requirements
- Incorporate the goals of the New Pathway in the current four-year program
- More computer instruction
- Better selection process

—Written responses from a March 1983 HMS student survey, "The New Pathway Questionnaire: What the Students are Thinking." *The Present Illness*.

Harrison's Textbook of Medicine or the medical edition of *Trivial Pursuit*? Some faculty members take Visit time to lecture on the case at hand (as a guaranteed percentage of the students catch up on sleep), and others skillfully make connections to their fields of research, which to any other mortal are completely unrelated.

Since it was the first day on the service for me and my fellow student, our resident presented the case of the day: an elderly woman with chronic but stable congestive heart failure decompensated unexpectedly despite her strict adherence to her medication schedule. She had to be hospitalized, since just breathing took Olympic effort. As the resident droned on about the patient's long list of medications, her other medical conditions that might or might not be related, and her lost seven-volume medical record, I settled back comfortably, assuming that on this Visit,

The medical course can not produce a physician. It can only provide the opportunities for a student to secure an elementary knowledge of the medical sciences and their application to health problems, a training in the methods and spirit of scientific inquiry, and the inspiration and point of view which come from association with those who are devoting themselves to education, research, and practice. Medicine must be learned by the student, for only a fraction can be taught by the faculty.

—W.C. Rappleye, director. *Medical Education: Final Report of the Commission on Medical Education*, 1932.

as with all previous ones in my experience, the only one on the hot seat would be the one who presented the patient. As the resident finished her presentation, and I was nodding off, our Attending broke the silence with a question. "Well, what caused this woman to decompensate and go into pulmonary edema, Paul?"

That last word—my name—caused the hair on the back of my neck to stand erect. "What? Huh? Who, me?" was the best I could manage for an initial response. He wasn't playing by the rules: he was asking me to analyze a problem—worse, to do it spontaneously! I stumbled through an attempt at an answer, picking on specifics and not taking a systematic approach to the analysis. To my surprise, what followed was a discussion of how to evaluate a medical problem—something that had been conspicuously absent from my medical education up to that point.

Suddenly basic science, which had stood in isolation for so long, took on new importance in understanding a relevant clinical situation. A dialectical synthesis revealed itself as these two previously opposing forces joined to create a whole. As this pattern was reinforced by my time in the hospital working with patients, many of my questions spawned in Amphitheatre C became answerable. Yet I was frustrated that it had been so difficult to arrive at this new level of understanding.

I came to realize the importance of student input into the framework of medical education. It not only makes students more involved in the material—building a foundation of lifelong learning habits and skills that physicians need in order to function in today's rapidly changing medical world—but also helps to bring teaching strategies up to date. At the administrative planning level, student input is a valuable tool in assisting

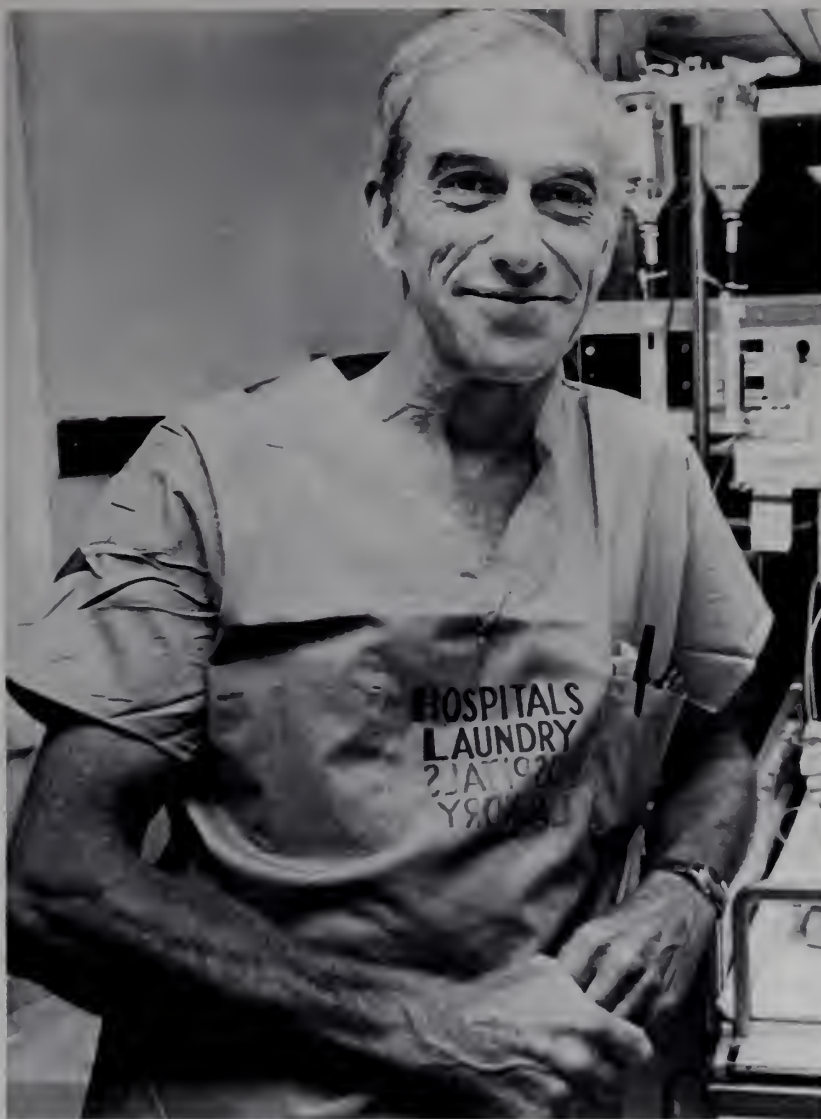
the faculty to lay out the educational framework of the curriculum. In keeping with this philosophy, I joined in on the planning of the Holmes Society.

□ □ □

My role in the New Pathway is multifocal, involving faculty and resource development, curriculum design, teaching, and liaison to current HMS students. One of my major projects this year is to expand and present Medicine 902, a month-long course for first-year students, using problem-based learning. Jeff Berman '85 developed and taught this course last year, to an enthusiastic reception by both the students and faculty members involved. My task is to develop new cases for the course—cases that will actually be used by Holmes Society students—and to use the course to train faculty members in the techniques of leading problem-based learning sessions.

My role as student liaison is particularly important since inadequate communication at the inception of planning led to an initially negative student reaction to the project. I hope to see increased student membership in the various planning groups. I would also like to see fourth-year students act as tutors, assisting first-year students with a wide range of clinical and basic science topics. A fourth-year elective is now being outlined that would focus on writing problems for use throughout the problem-based curriculum.

The Oliver Wendell Holmes Society is not merely another in a long line of HMS curriculum revisions, but a critical reexamination of the philosophy that underlies medical education today. This analysis, and the resulting plan of action, has student participation as part of its heart and soul, and an essential criterion of its ultimate success. □



Introducing Will Cochran, New Alumni Director

To prepare a profile of Will Cochran '52, newly installed director of Alumni Relations, the Bulletin staff dug into the archives—and found that, in his class reports for Harvard College ('45) and Harvard Medical School, he had already done most of the job. Presented below is an abbreviated collection of those reports.

Cochran is currently associate clinical professor of pediatrics at HMS, and physician in charge of Newborn Nurseries at Beth Israel Hospital. He is on the faculty of the Joint Program in Neonatology at Beth Israel, Brigham and Women's, and Children's hospitals. His teaching has been honored with two awards: the Children's Hospital House Officers Teaching Excellence Award in 1977, and the Valentina Donahue-Turner Award for Excellence in Teaching from the HMS Class of 1981.

Cochran has long served HMS in a number of capacities. He has been president and fund agent of his class since 1952; chairman of the first Alumni Survey Committee, which produced a report on admissions in 1973; a member of a task force on the admissions process; a member of the Committee on Admissions since 1976; and chairman of the Subcommittee on Minority Admissions. He left his admissions work last spring to make way for his new responsibilities.

To find out about Cochran's plans for the alumni, we tracked him down in the neonatology ward at BWH, where he spoke of finding ways of giving recognition to remarkable alumni who are not well known. "Instead of the Nobel Prize," he said, "maybe we can come up with a 'Noble Prize.'" He also spoke of his love of teaching—and then proceeded to teach us, making clear and simple the treatment of infants who would not have survived only a few short years ago.

Two of Cochran's new constituency have experienced his reign before: son David '79, and daughter Nancy '81. Another physician daughter, Susan, was recently profiled in a New Yorker piece on family doctors.

1955 Harvard College Report

At present I am gainfully employed both professionally and socially in taking care of the future All Americans, Lana Turners, Stevensons, Eisenhowers, Batchelors, McCarthys, Willie Mayses, and possible Willie Suttons. It is very difficult to tell which is which under a diaper. I am in my last year of residency in pediatrics at Children's Medical Center.

Over the past few years I have voted Republican (and cursed myself), voted Democratic (and cursed myself), not voted at all (and cursed myself); I have caught a mild case of paralytic polio (and cursed the virus), but have completely recovered; become an even more ardent fisherman and duck hunter with very little material gain but great philosophical advance; become a home owner of a ranch-type project house which has a big window facing all the other houses with their big windows; and last, and certainly foremost, have gradually acquired a family that seems to satisfy all my Freudian drives both by begetting and having around me.

My future is dim but it deals with taking care of the common child, I hope.

1957 HMS Reunion Report

Type of work: My greatest problem is balancing home life and pediatrics, the latter becoming bigger and bigger, the former becoming larger and larger! Am on the teaching staff (if anyone wants to call it "teaching") of Lawrence and Memorial Hospitals. This is where we send our private patients, where our newborns are, and where we have the ward service. Am on the consulting staff of the Seaside Sanatorium (TB).

Personal history: After leaving the Three-H Club (Harvard's Hallowed Halls), I moved about 200 feet into one of the worst phases of my life, the intern-residency routine. I look back on Children's Hospital now with mixed emotions, but at the beginning

of internship it was to me all gruesome. My attitude was changed the third year out when we were paid \$9.41 a week. That was the year we bought the goldfish.

Somewhere along in the second year, to prove that men in white suits are clean but not sterile, I managed to beget my last child (so far). Although I was treated wonderfully and really enjoyed my last year in training I revelled, laughed, and screamed for joy at the end of said year.

Now I'm peeking under diapers daily looking for the rare syndromes and finding only poooh (not the bear) or simple rashes; listening to chests and hearing only normal hearts; checking head circumferences, lengths, and heights only to find them following the 90 percent with startling regularity. To one with a more complicated brain than mine, this would seem boring—but somehow it gives me a boot.

Frank Ingraham has called New London the "Armpit of New England." He's probably right but since we live near the ocean the salt air provides enough Odor-o-no so that we love it here. My big battle is now, as it probably always will be, how to feel like I'm doing my part in this atomic age and still have enough time for my wonderful wife and growing children. I'll not bore you with the more detailed mental gymnastics. As a parting note, having once been honored as standard bearer in a stuffed ballot election, I might point out that I can easily be replaced. All you have to do is appear at the reunion and dethrone me. I'm hoping that the prospect of this possibility will double the turnout!

1960 Harvard College Report

Since the last report, I've grown five years older, little, if any, wiser, and I still don't know what it's all about! I have been practicing pediatrics in New London. I hope it does somebody some good. It continues to amaze me how much credit antibiotics and doctors get for the inevitable recovery of

most diseases and conditions. I guess so long as we are well motivated, our profession will flourish.

Having a great hate for the ever-present telephone and the fact that it is easier to dial a number than use your head, I have two highly esteemed partners who enable me to get off the hook and enjoy my wonderful family and do something with them besides gaze upon them when they are sleeping. I still hope to teach somewhere, but no one thinks any more highly of me than I do, so I'm doomed to this life, I guess.

Having failed to be the first to climb Mt. Everest, fly more than the speed of the earth's rotation, be picked as one of the astronauts, beget quintuplets, beat Tom Dooley into Laos or Schweitzer into Africa, or to have played football in the Harvard Stadium, I firmly believe that what I have to say will be of little note nor long remembered. However, I favor disarmament outside of the United Nations, or, as Tom Lehrer—the famous singing poet from Harvard—says in his newest hymn, “We will all go together when we go.” I would like to see our food surpluses sent to starving countries with a packet of directions for birth control in each can (like the prizes in Cracker Jack). I look forward to visiting my son on Mars, Venus, or Jupiter. I continue to contribute more (not a lot!) to our church than I do to Harvard.

1962 HMS Reunion Report

Medical Work: After five years in a pediatric group practice in New London, Connecticut, I snapped up the chance to participate in a 12-hospital prospective study of cerebral palsy, part of NIH (NINDB). I have teaching and hospital appointments at Boston Lying-In, Children's, and Massachusetts General hospitals.

The front lines of pediatrics were too much for me. The patients I loved; some of the parents' questions were unbelievable. I believe in moving



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well known.*

nurses to the front lines, after elevating them to the status of junior pediatricians following a period of training—so clods like me can go back into office practice without being dunned to death. I wouldn't force this on anyone, but I'd snap at the chance! After my first three years in practice, my then six-year-old could spell three words: “Naney,” “Cat,” and “Neosynephrine.”

I struggle at some extra clinical research but am the world's most slovenly thinker, so find myself staggering in abysmal ignorance—plus making stupid mistakes. Feel that the only journal worth reading would not allow author's name; then what's printed would be there for a more wholesome reason.

Activities since 1957: I still feel strongly about clean living and exercise—especially when I'm doing neither. It's all I can do to brush my hair 100 strokes a day without getting cramps in my arm. My political leanings are more liberal if anything—now tinged with overt hysteria at times. We live in a 160-year-old farm house, so we fear fall-in much more than fall-out. The cellar is so full of supporting paste all around that it's all I can do to maneuver the rowboat down there when the spring rain floods the cellar. If it weren't for my wonderful family and the world's greatest lady for a wife, I'm sure life would lose most of its wonderful charm.

1965 Harvard College Report

I've been largely in research at the Boston Lying-In, running the pediatric side of an NIH-granted colossus that studies the obstetric causes of cerebral palsy, mental deficiency, and birth defects. Some of it is pure seat work, but it allows me time to think, some time to write, moderate time to teach heresy to medical students, and I do get involved somewhat in the practice of medicine.

I continue to love that girl called “my wife” in spite of her frustration at the “uselessness” of her life as she works hard to bring up the children, who often don't seem to appreciate the effort at all.

We sorely miss John Kennedy as the figurehead of America and think Albert Schweitzer, Gandhi, and Martin Luther King are “the greatest.” I yearn for a policy of desirable but free immigration, but freely admit I'd like to be at or near the top of the

pile—only wishing the pile was made up of all kinds.

My favorite hobby is daydreaming—dreaming about a scientific study, dreaming about teaching underprivileged in Roxbury, dreaming about the U.S.S. *Hope*, hoping to write a book on immigration. I'm one of the world's great dreamers but rate the bottom of the list of doers. I blame it all on being a Harvard man.

1970 Harvard College Report

"I'm no longer the man I never was." I wish I knew who first said that, for it says so much so well! I will add, I will never be the man I dream of being. Politically I look for heroes that either melt before my heated gaze or are murdered. If I could resurrect one (and he was not really political), it would be Martin Luther King. He did much to keep my hopes alive that somehow, eventually, all would be well. What style he had when he was steamed up! Now there isn't anyone who hasn't got some blemish (either personal or political), so I'm just waiting. I have voted both sides but call myself a Democrat. Political entomologists would probably hang the "fuzzy liberal" label around my neck.

Socially, I believe in the family as the most desired and desirable basic unit on which to build a stable society. Whatever makes marriages happy and permanent I am for. Perhaps the social anthropologists, with the help of characters like Robert Ardrey and his book *African Genesis*, will show us how the ambivalence of man (one minute philosophical, the next reacting from the gut) can develop a society that isn't too restrictive either way. I doubt premarital sex or trial marriages are the answer at all (though they may be), and I get very upset when unwed pregnancy evolves. With instant gratification, the whole basis of romance—the fanciful and the unreal—is gone.

Professionally, I enjoy teaching, caring for, and doing a modicum of research on, newborn infants. They are largely untouched by society,

presenting themselves as "pure substrate." All I have found out so far is how little we really know.

My wife and I have had great times, shared new ideas, remembered old experiences, had lots of laughs, occasionally strongly disagreed. We are probably too proud of our children. I hope our luck holds for another 25 years at least.

1977 HMS Reunion Report

My major hobbies are talking about going jogging, cross-country skiing, cruising, skiing, hunting, fishing. My minor hobbies are doing those that I talk about, and also tennis, sailboat racing, and bird watching.

Since 1972: I have continued my losing battle with father time but look on it philosophically as a medical education.

Since last writing, my wife, Marybelle, has become a full-fledged social worker concentrating on family dissolution. All five offspring are now past high school. Two oldest are in medical school, we are proud (but slightly embarrassed) to relate, and the third is applying "all over," trying to get in any place next year. The two youngest are determined to live a different lifestyle but so were the three oldest not too long ago, so Marybelle and I "just watch."

I have, I guess, now started to retreat slowly from my top level of incompetence, where I was running the newborn service at Boston Lying-In. I now work on a team at three hospitals: Boston Lying-In and on the newborn services of Children's and Beth Israel. It has been great fun being in on the quantum jump that neonatology has taken in the last 10 years, though I wish occasionally for the old days when one observed and treated the patient rather than the lab book. Now it seems the patient is often "trolled through the lab to see what bites," and some days the fish are really biting. I get to do a lot of teaching, which I enjoy immensely. I'm urged to do research and publish;

perish the thought! Eighty percent of the time I'm happy going to work in the morning; 100 percent of the time I'm ecstatic going home at night.

Thanks to all you classmates who 25 years ago had the misguided desire to elect me class leader. I've been appointed to the HMS Alumni Survey Committee and from there to the Admissions Committee. Both have been educational and fun. It gives me a chance to "say my piece" about what I think HMS ought to be, and who ought to be its students. Since I'm the only one on the Admissions Committee who ever was in non-academic primary care, I argue, rightly or wrongly, from that vantage point.

To sum up, for a 25th report, if I had to do it all over again, I'd try to marry Marybelle, go to Harvard, have five children, practice pediatrics, and become a neonatologist. I hope I'd be as happy the second time around.

1980 Harvard College Report

In the past ten years I have continued pretty much in the same geographic area—I have turned myself into a subspecialist in a field that was just created in 1976. Believing in primary care as the epitome of medicine, I am sorry I have not remained a pediatrician but am pleased to have helped develop neonatology.

I'm still a frustrated Democrat—against what I see as over spending for overkill, and only lip service for what could and should be a big program for alternate energy (at the moment not nuclear until at least hydrogen can be harnessed). I am still *very* optimistic but feel the future will be quite different than the recent past.

My three oldest children are in medicine and that is nice, but mostly I'd like them to be happy, which sometimes they are not. If anyone has an infallible happiness formula I hope he'll present it at the reunion. Next to youngest is into computer science and youngest plans a political career. They are a great family to me. □

A Talk with the New Dean for Resources



by Lisa W. Drew

Fund raising is a two-part educational process: first alerting alumni and friends that HMS has serious financial needs, then informing those who are interested about how they can help.

Harvard Medical School is gearing up for a major capital campaign. Weekly Development Office staff meetings start promptly Mondays at 8:30; computers are on their way; and while the Alumni Office is being renovated to house part of the Development Office (in addition to the Alumni Association and Alumni Fund), new development staff members play musical offices between the basement and upper reaches of Building A.

Presiding over it all is new dean for resources William K. Stone, freshly transplanted from University of Florida, where he was director of university development. Stone, a 1958 graduate of Harvard College, spent the first decade of his career in business before moving into fund raising in 1970. During his last five years at University of Florida, private support more than doubled, and gifts to the university's foundation more than tripled.

At HMS, Stone will be guiding the development program and capital campaign. He believes "HMS is at a crossroads; what happens in the next five to seven years in securing additional resources will have a major effect on the future quality of the school."

In the following interview, he talks about the needs of the school, his plans for meeting those needs, and his function as a catalyst for bringing together the interests of donors and the school.

Previous page: William Stone seated before the portrait of Ezekiel Hersey, first donor to HMS. Hersey gave 1,000 pounds to Harvard in 1772, 10 years before the founding of HMS. With other Hersey family gifts, two endowed chairs were established in 1792; both are still active. The portrait now hangs in Stoue's office.

HMAB: Let's start with what brought you to HMS.

WS: I was interested in the idea of a campaign—and, being an alumnus of the college, I found it attractive to return to the same institution. When you're approached by Harvard, you have to at least take a look. It was stimulating to meet Dean Tosteson and the other deans here; I was inspired by their enthusiasm and genuine feelings about HMS—its leading position and new directions.

HMAB: Is that the same campaign that's been in the works? When will it be launched?

WS: Yes; it's a major capital campaign the school has been gearing up for since its Bicentennial. It will be formally announced about January 1986.

HMAB: I imagine you run across skepticism that Harvard Medical School really needs money. How do you answer that question?

WS: Although HMS has an impressive-sounding endowment of over \$200 million, that amount is far from sufficient to meet current needs. Virtually all of it is restricted for such purposes as professorships and research funds.

There is a great need for scholarship funds. The rapid inflation in this country in the last 20 years has created enormous pressures on the budget here, and as a result has also created enormous financial burdens for medical students. The costs well exceed

the amount of available scholarship funds. HMS tuition this year is \$12,100. The approximate total cost of four years of HMS education for a student entering this year substantially exceeds \$50,000. To endow that costs approximately \$1 million.

Endowments for chairs also have inflated. A chair that might have required \$150,000 20 years ago requires \$1.5 million today.

A third need concerns the physical plant. As you know, the Quadrangle is 78 years old. Although some of the buildings have undergone significant renovation, others are in poor condition; Building E, for example, has not had any renovation since its construction in 1906. Vanderbilt Hall is in serious, deteriorating condition. Although it received a much-needed facelift in the late '70s, it has not had any significant renovation since its construction in 1927. The pressure for space is also serious; the space needs of the school both now and in the future are presently being assessed.

HMAB: A new relationship is being formed between the Development Office and the Alumni Fund. How is that taking shape?

WS: As you've reported in the *Bulletin*, Carl Walter has stepped down as chairman of the Alumni Fund, and Joe Murray has taken over as interim chairman. He has taken over a solid program from Carl Walter, primarily based on an effective class agent system. A person in this office will support the chairperson of the Alumni Fund in his or her efforts to secure annual support from alumni.

HMAB: So the staff for the Alumni Fund will be with the Development Office?

WS: Yes. There will be a director of annual giving in the Development Office who is responsible to the chair-

I enjoyed the business world, but I was looking for something other than what I found there. I hope my efforts help others create something of enduring value for society.

person of the Alumni Fund. Annual giving encompasses unrestricted gifts from many sources—alumni, individuals, and corporations. The Alumni Fund includes only gifts from alumni.

HMAB: Will Carl Walter still be involved?

WS: Yes. Carl will be working with us to identify and help attract major gifts. That will be a significant fund-raising responsibility, a critical one for the forthcoming campaign.

HMAB: What groups do you consider to be potential donors, and what do they get back from a relationship with the school?

WS: The most important constituency of any school, especially of this one, is the alumni. They form the foundation upon which everything else is built. As they have in the past, HMS alumni will play a major role in the development program, both with help on the campaign and with gifts. They are graduates of the finest medical school in America, and their alma mater needs their financial investment to ensure its continued leadership in education and research.

Another constituency with enormous potential is friends of the medical school—primarily those who have been patients of the various clinical faculty.

A third area is the corporate world—very important, but in a different way. There we will look for gifts to current operations and research that may or may not be part of campaign goals, but still important to the development program as a whole. Fourth is the area of foundations, critical to the New Pathway [see article this issue], to general operating support for different programs, research, and, to a lesser extent, construction and endowment.

We will have a senior development person in each of the following areas: corporate foundation; major gifts

from patients; alumni fund raising, including the annual Alumni Fund and major gifts; and a deferred giving program. Each will have significant staffing, hopefully on board by this January.

HMAB: You said to me recently that fund raising is an educational process. What can the alumni expect from your office?

WS: Fund raising is an educational process from two standpoints. The first involves alerting alumni and friends that HMS has serious financial needs, and that those needs fall into the categories I've mentioned.

The second involves educating those who want to help about the many ways they can make a gift. Most people think in terms of cash when they are asked for a charitable donation. But usually a large gift for an endowment is in a form other than cash—securities, for example, or land, or artwork.

The two most important assets are land—improved and unimproved property—and securities. Many people don't realize they can avoid capital gains tax on gifts of securities and land. In addition, regardless of what a donor gives, he or she is entitled to a charitable deduction for the full value of the property, which produces some fairly significant tax savings. The deduction, in effect, reduces the cost of the gift. If someone gives \$1.5 million for a chair, and he or she is in the 50 percent tax bracket, then the cost of the gift in actual terms is only \$750,000—even

less, if future estate taxes are considered.

Donors have their own needs and interests, and the needs at HMS are very real. If I can act as a catalyst to bring both together, I've really accomplished something meaningful.

HMAB: I noticed on your resume that before you went into development you worked as a securities broker, for a bank, and for an actuarial firm. Then you took two years off to write fiction before pursuing this career. Why the switch? And does it have to do with why you're here today?

WS: I enjoyed the business world, but I was looking for something other than what I found there. Everything I did there, surprisingly—and as I look back on it, it's almost as if I was being directed toward development—has been helpful in this work. I hope to bring together a total program that will include helping individuals do something meaningful with their hard-earned assets. People with money don't always know what to do with it. Even parents don't always want to give all their assets to their children. If they don't, they only have one choice: give it to charity. They certainly won't give it to the federal government.

I'm helping people more than I did in business. And it's a more direct help. I work on estate plans, for instance, and even if potential donors don't give us anything, I feel I've helped them resolve the distribution of their assets—a serious problem in their lives. I feel that all my life I've been preparing and educating myself to become a better fund raiser, even though I only started in this business 14 years ago. I enjoy it and find it fascinating.

I hope my efforts alert people to the many opportunities they have to create something of enduring value for society—investing in Harvard Medical School to improve medical education and research.

The Long Journey Back

by Deborah Zamcheck Atwood
and Kimball Atwood

On December 2, 1982, Deborah Atwood, manager of Vanderbilt Hall and veteran of four Boston Marathons, started off on her usual daily run. As she crossed Commonwealth Avenue near the BU bridge, a car struck her, leaving her with 16 fractured bones. She was rushed to Brigham and Women's Hospital, where it was estimated she had about a 10 percent chance of survival.

Deborah's husband, Kimball Atwood '79, then an internist and anesthesiology resident at Beth Israel Hospital, watched and helped her through her long and painful recuperation. She remained in the hospital for six months, eventually undergoing physical, occupational, and speech therapy.

In February 1984, more than a year after the accident, Deborah and Kim spoke to an audience of HMS students and faculty at a Henderson Society meeting. They talked about what they had learned about doctor-patient relations from the perspectives of the patient and a spouse who is also a doctor. This two-part article is an adaptation of their presentation.

Deborah returned to BWH in March 1984 for hip surgery, which will eventually allow her to walk without either crutches or cane. She has replaced her running with a mile-long swim. In October, she returned to HMS to start a new job in the Development Office.

DEBORAH ATWOOD: It is particularly meaningful that I am speaking to you tonight because almost exactly a year ago, February 7, 1983, I had the shocking experience of waking up in a hospital, not having the faintest idea of why I was there.

I was lying on a very strange bed that had a motor underneath it. (I later learned it was called a Clina-tron or sandbed.) I had terrible pain throughout my right leg and wasn't able to move it. Across the room I saw a bulletin board which read: "Deborah Atwood, The Brigham and Women's Hospital, February 1983."

My last memory was of the Jordan Marsh Thanksgiving Day Road Race.

My husband, Kim, spent much of that day telling me what had happened to me. He told me that over nine weeks earlier I'd been running at noontime from Vanderbilt Hall, as I did most days, and that I'd been hit by a car that had run a red light. I'd been picked up, almost immediately, by an ambulance and taken, unconscious and unidentified, to Brigham and Women's Hospital.

I was in surgery for 12 hours. Both of my legs and my right arm were broken; I had two skull, two facial, and multiple pelvic fractures. I was in coma for 25 days and very disoriented and confused for about six weeks thereafter.

What made my life in the hospital

bearable was the incredible care and support I received from my family and friends. I needed a great deal of reassurance in the early months: Would I ever walk again? Would I, one day, lead a normal life? I asked absolutely everyone all the time: Am I getting better? Am I getting better? My family visited me daily, giving me not only hope about my recovery and future, but help with remembering many aspects of my life that I'd forgotten.

Several of my nurses took the extra time to talk to me and reassure me. They could see my progress and recovery more objectively and clearly than I could. I had never before given nurses the credit they deserve.

Many of the doctors who had initially taken care of me visited me throughout the seven and a half months I lived at the hospital. One, who had been in the Emergency Ward when I came in, had been very ambivalent about resuscitating me: I was in such awful condition that he didn't know if he was doing me a favor. When he later learned my identity, he confessed his initial uncertainty to my father—Norman Zamcheck '43A—with whom he had previously worked. My father suggested that he speak with me again. He visited me on the Neurological Floor, told me he had worried that maybe he had done the wrong thing, and said he would never have that doubt again. I





thought it was courageous of him to speak so honestly, and I was pleased that he had learned something important from his experience with me—that, at some level, I had contributed to his life as he had to mine. During the visit, he wrote in my journal, “It was worth all of the pain and anguish for us both.”

I had only one negative experience with a physician during all my time in the hospital. One day, when I was still living on the sandbed, an orthopedic resident came to see me. He had never seen me before and, I was told later, didn’t know a great deal about me. I asked him if I would ever walk again. He responded, “You will never walk normally again.” I was in utter despair for the rest of that day. I never saw that resident again. I tell you this because I feel that it is terribly important to give patients hope, especially when it is warranted, as it was in my case.

I didn’t leave the sandbed until early March. First I was put onto a tilt table; next I walked a few feet with the support of parallel bars; then I walked—first with a walker and then crutches, still only for a few feet. Today I use a cane at home, which lets me use my right hand and arm, and crutches for longer distances.

Many people ask me about my future. In time, I’ll be able to do many things I’m unable to do now, such as walk without either crutches or a cane. I look forward to leading an independent and normal life again.

KIM ATWOOD: Deborah asked me to speak to you about what it was like to be a physician, well versed in the care of critically ill patients, whose wife was suddenly critically ill. I could barely begin to cover this huge topic tonight, but I’ve chosen a couple of impressions to share with you about the ways we doctors deal with patients and family members.

First, in the early days of Deborah’s hospitalization, I was struck by the overwhelming sense of gloom conveyed to me by her doctors. At that time I found myself almost constantly and desperately imagining a

scenario in which she would get better—not that I was fooling myself as to the gravity of her condition, but even *with* that understanding I needed a medically plausible sense of hope, and *I needed her doctors to provide it!* This was true even though I myself was perfectly capable of inventing my own scenario of Deborah’s recovery—and for that reason I believe it to be a crucial feature of the doctor-patient or doctor-family interaction, regardless of the latter’s level of medical expertise. Pessimism on the part of doctors is, in my experience, not uncommon; but when looked at from the point of view of the patient or family member it is unnecessary and probably far more painful than most physicians, especially young ones, can imagine. Why many doctors feel compelled to take this sort of stance is undoubtedly a complicated issue, but I believe it may involve, among other factors, an unfortunate interpretation of the consumer movement as it applies to doctor-patient relations—which is to say that brutal honesty is viewed as the correct way to approach discussions of prognosis. In addition, there seems to be a feeling among physicians that litigation may result if a favorable prediction is proven wrong. I consider both these rationales to be wrong. The fact that Deborah *did* get better is all the more reason, albeit in retrospect, for her doctors to have offered a more positive outlook.

Let’s examine the incident, already



described by Deborah, in which she was told by an orthopedic house officer that she might never walk normally again. In this case, a presumably well-meaning resident fell into the trap of making a deeply painful statement to a patient simply because he may not have been thinking about the total picture. It should have occurred to him, since he was just meeting Deborah for the first time after she had been hospitalized for approximately four months, that the subject must have come up before and that perhaps he should defer to others. It also should have occurred to him that Deborah had problems besides a hip and sciatic nerve injury, most notably a head injury, that could figure in her response to his words.

John Stoeckle, chief of medical clinics and director of primary care at MGH, has discussed what he calls the two "agendas" of any doctor-patient interaction—the doctor's and the patient's—and the importance of the doctor recognizing the potential differences between the two. I believe that in this case the house officer's most important error was that this notion of differing agendas did not even cross his mind, and yet it was the most important part of the interaction. When Deborah asked, "Will I ever walk again?" she was *not* asking, "Will my gait be indistinguishable from normal?" What she was asking was a series of questions, including: "Will I ever get out of bed? Out of this hospital? Will I achieve independence in activities of daily living? Will my friends and family still love me?"

The house officer's agenda, on the other hand, was to demonstrate his relatively newfound knowledge concerning joint stability and mobility, the natural history of damaged peripheral nerves, and other such matters. In following his own agenda and neglecting that of the patient, he unwittingly tyrannized her.

A second, related issue has to do with attitudes about intensive care units. You will find, if you haven't already, that in some types of ICUs health professionals feel a sense of futility due to the expenditure of so much equipment, technology, and labor to achieve such dubious benefits. In my experience, this feeling is especially strong in cases of hopelessly ill patients, such as very old people with multiple organ system failures, or those with terminal diseases such



as widely metastatic cancer, being "kept alive" by machines. In these instances, there may well be valid arguments against committing the resources of ICUs to their care.

There is a tendency, however, to extrapolate this sort of thinking to many types of critically ill patients whose prognoses are grave—an obviously dangerous point of view. I want to make this point particularly to you, for as future house officers it will be *you* who among physicians are most

heavily taxed, physically and emotionally, by taking care of critically ill patients, often with little reward. You will inevitably develop ambivalence concerning these efforts. I think it's fair to say, however, that Deborah's dramatic recovery has helped convince many of us, including a generation of house officers at BWI and several of my colleagues and HMS classmates, of the validity of "high-tech" medicine. I hope this feeling has been imparted to you tonight.



Second Chances

by Edward Hallowell

Over a year ago, the Bulletin staff attended a presentation by a pair of psychiatrists at Massachusetts Mental Health Center—Edward Hallowell and Henry Smith '72—about a patient who had responded to therapy in which he wrote alternate lines of poems with his psychiatrist. We tracked down Hallowell, who had worked with the patient, in hopes of extracting an article from him about the experience. He was tied up, he said, with work

on a novel. One year later, he showed us the manuscript, and we found in the fiction what had interested us in real life: a collaborative effort between doctor and patient.

In the following excerpts from the novel, Jay Weinstein is a patient recently transferred from one psychiatric hospital to another. He has been institutionalized for 16 years. His new psychiatrist is a resident named Chris Aymes.

ILLUSTRATION BY JAMIE HOGAN

They didn't say good-bye to me," Jay said some minutes into the session. Humid amber air filled Chris's office, air that Jay was gradually graying with smoke. Once exhaled, the smoke seemed to form an organism of its own, each lungful adding substance to the filmy cloud. "You may not think that matters, but you walk in and out of places all the time. I was stuck there."

"You made friends."

"That surprises you? A fat slob like me making friends? Well, as a matter of fact I did. None of them were doctors, don't get me wrong."

"But there were . . ."

"There were others," Jay paused. Chris wondered whether Jay's moods today were due to the medicine. "And not one said good-bye." He looked down at the floor.

"There have been other times you didn't get to say good-bye?"

Quickly Jay snapped out of his melancholy repose. "Why do you say that?" he demanded. He sat back in the chair; Chris saw an excitement steal into his eyes. "You know, you really don't play this game very well at all. But what can I expect. You're only a resident, right?" When he said "resident" he gave the word his playful three-tone inflection. "A Wasp resident. Or a resident Wasp. Why didn't you go to New York or Boston? Couldn't you get in?"

"I seem to have made you angry."

"You think you're pretty slick, but you're not. I know what you're gonna say before you say it. What do I need you for? I could do this on myself."

"It's no good trusting people," Chris said.

"You're right!" Jay proclaimed, and stood up from his chair. "It's no good trusting you. Who are you anyway?" He began to march around the room. "Now I'm pacing. You probably think I'm getting high. You probably are beginning to worry you'll have to get the guards in here. But you don't call them guards, do you? I bet you're worried. Good. Worry. I worry all the time. Why shouldn't you worry?" He was puffing vigorously on his cigarette so that the smoke creature, now grown the size of the room, was having to double back on itself, connecting in folds and swirls all the air in the room, involving the humidity and the sunlight in its graying skin.

"No good worrying alone," Chris said.

"You're right, smart-ass. It is no good. But what are my options." He put his hands behind his back, holding his cigarette behind him like a secret prize. Occasionally he would pull it forward for a puff, at those points allowing the arm without the cigarette to hang loose, a forgotten wing. Then he would return his hands to a clasped position behind his back.

Soon he fell silent, the pacing and the smoking taking on a rhythm perhaps in time with his thoughts.

Options, Jay thought. Who has options. Options and foptions. This guy's a foption. Half an option. Gotta get out. Gotta run. No place to run. Dammit, gotta run. Run for the fun. The fun. Where's the fun. I know the fun. The funnest fun is the funniest fun in the world those funny farm funheads wouldn't say good-bye.

"Mr. Weinstein?"

Mr. Weinstein he says. That foption. Foption fun. Fun for the run. Run. Run.

Jay turned toward the door. "Don't give me that crap, Aymes. This is foptional. I choose to foption out." He left the room puffing.

Chris began to feel mild panic of his own. He felt he was coming to understand Jay, to read in the creases of his face, how they widened, how they narrowed, the churning he contended with. And as Chris felt it in himself he got scared. This empathy stuff Steinetz talks about is fine for some people, but for me? Quick scenes flipped through his mind like a fast-paced slide show. Pop on the bike, Pop on the ward.

The times he visited his father were so hard to make sense of. Chris never knew what to expect. One time Pop insisted on playing hopscotch and calling out the numbers in French. Another time he brought out a rope and gave Chris a lesson on knot-tying. Once in a while he made some sense, but the unpredictability kept Chris from ever relying on him, really from even thinking of him as a father. He couldn't help feeling that the illness was a giant rejection, and when he let himself he hated his father for it. So, less and less he let himself, keeping a distance.

But now, through Jay, he felt he was beginning to understand what it was like for Pop, and it made him so sad he felt frightened, for Pop, for himself.

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*He much preferred
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The visits were never easy.
Chris came out of secret,
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When people ask you about your father," his grandmother had said to Chris when he was a child, "just say he manages investments. Don't say anything about the hospital. People don't understand that sort of thing."

"Can I ask you about it?"

"It's a hospital for people who are tired."

"How long will he be there?"

"We don't know. A long time, probably."

"He's that tired?"

"It's a special kind of tired. Now please don't ask me any questions because I don't know the answers." Gammy leaned down and gave Chris a kiss on his cheek. He could tell she was crying.

But he had taken Gammy's advice, gone off to school and said no more about it. Boarding schools became his family as his real family quietly and with good manners disintegrated. His parents divorced because his mother didn't want to be married to a crazy person, his father reduced the family fortune from millions to thousands before anyone knew what was going on, and the one person who held the family together, Gammy Aymes, died. His mother became alcoholic and lived in the past, dying when Chris was in college.

His father never made it out of the hospital, although he did get trial passes now and then. On one such pass he came to a soccer game Chris was playing in and stood apart from the crowd, placing himself under the trees at the far sideline. By the time the game was over and Chris went to look for him he was gone.

That was how he thought of him now. Gone too soon. But you tried, Pop. That's the hell of it, isn't it. When the bug hits, no matter how hard you try, you're still in circles on a bike, huh?

The last time he'd seen Pop was in the V.A. Hospital in Bedford, Massachusetts. Chris, in his last year of medical school, drove out on a clear fall afternoon, one of those pellucid autumn days in New England where the clarity of the air crackles and witches' colors bank the highways.

There is a deserted quality many large mental hospitals have that betrays the chaos they conceal. Up an outside wrought-iron stairway into a lobby, through an empty waiting area, past an unattended receptionist's

desk, down a half flight of stairs, through a tunnel following the green arrows to W-3, where an attendant wearing a white T-shirt and white pants told Chris Mr. Aymes was out on the grounds, on pass.

That was good. He much preferred to see Pop outdoors. The visits were never easy. Chris came out of secret, waning hope that there would be a big change, out of duty, out of whatever it is that keeps us all coming back to our parents for what they can't give. But no one else came. Gammy had come every Sunday to take him for dinner until she died. Chris's older brother and sister had both moved out of the country years ago. And the extended family, the uncles and aunts and cousins once and twice removed, the many influential Aymeses, had drifted away ever so politely when it became clear that this Aymes was insane.

It was as if the madness were simply too incorrect to be permitted. Something along the lines of a Jew in the Country Club, but not so political; more a fact upon which there would need be no debate. That virtually every blue-blooded Anglo-Saxon family in the Northeast sported one or two insane members didn't rally support. Ostracization is too active a word; it was more an easing away, a process from we-seem-to-have-lost-touch to no mention at all.

If the money had been maintained the process would have taken much longer, but with the money gone, the children sent away and modestly trust-funded, the matriarch dead, the wife never having been one of us in the first place, and the man with the embarrassing illness housed, there was no cause for the invisible force that binds families into clans to include this branch of the Aymeses. There was no malice involved, not even anyone reaching a decision, rather, simply, the pitiless pragmatism for which the ethnic group is famous.

Chris himself had put distance from what had once been his family. He did it instinctively, at schools, to get on with things, as one does, perhaps, after a death. There had been no death, exactly, but that day of his father's nude bicycle ride had marked a transformation just as final.

Yet the mark had been made: Chris had decided to work with the very illness that had taken his father from him. He was going to tell him

that today, if Pop would let him.

Chris found his father sitting on one of the lower branches of an apple tree. "Hiya, Pop."

His father tossed him an apple and jumped down from the tree. He still had the athletic good looks of his youth. Father and son looked alike: tall, trim, sandy blond hair, off-blue eyes and a square-jawed straightforwardness. Chris contended more with self-doubt, and he carried himself in a hands-in-pockets, down-looking way. But when he looked up, as he did at his father now, there was an openness about him that people would trust.

They chatted for a while, strolling around under the tree, Chris testing the waters, until he realized Pop wasn't making much sense. But he wanted to tell him anyway. "So, I've decided."

"Good," Pop said, before he knew what Chris had decided about. "It's bad to sleep with an unmade decision."

"I'm going to be a psychiatrist."

"Good boy. You can take care of your mother."

"She's been dead some time, Pop."

"Oh, well, that's too bad."

"So, what do you think?"

"Penny for my thoughts. Everyone around here wants to know what I think. I don't think. Do you think?"

"Don't you have any reaction at all?" Chris felt ashamed: why should he insist on a reaction from a man who couldn't keep the days straight or remember the death of his wife? But wasn't he entitled to some reaction?

"I always thought you'd be a pitcher, not a catcher. That's my reaction."

"But you always told me the catcher is the key to the team," Chris said, delighted.

"Yeah, but he gets beat up. Stubby fingers. Foul tips. Buy a good cup, too. Remember Pinky Alonzo? No, you never came to the games, did you. He was the only one I'd pitch to." Pop started to wind up and pitch while he talked. "We had rhythm, that's the key. So you want to be a catcher, huh. Take a lot of abuse."

"I don't have the arm to be a pitcher. And I want to play every day." It didn't matter to Chris now whether the metaphor made any sense—although he thought it did—or even if Pop really knew what they were talking about; it was exhilarating just to connect with him, even on some for-

gotten baseball diamond.

"It's a good way to the big leagues, though. Catchers are always in demand." Pop paused at the top of his windup. Then he brought his arm around and whipped off a curveball. "You know what it was with Pinky? Why we got a good rhythm? He could handle whatever I threw. If I was wild one day, I knew he'd take it, not get riled. If I was in a groove, I knew he'd keep me there, not try and call some pitch I couldn't throw. Maybe I'll introduce him to you someday."

"That would be great, Pop."

That was their last conversation. With the embarrassing inevitability that seems to drive most lives, Chris had ended up in psychiatry. And now he was going to find out. Find out if he'd go nuts, find out if he could take care of the crazy people, find out what this bug that had so changed his life was all about.

And his first real teacher was to be this big, fat man named Jay.

"Me Jew. You Wasp. Impossible," Jay had said at their next meeting.

"What do you mean?" Chris had asked.

"What do *you* mean 'What do you mean?' Feh. You better come up with sexier questions than that. I mean, Dr. Aymes, that it's like fire and ice."

"Water puts out fire," Chris said.

"Not bad. You get a point. What do you know about fire, anyway?"

"I want you to tell me."

"It's hot. It burns," Jay sighed. "I'm getting bored. Can you get me a date with that nurse?"

After Jay escaped from the hospital and returned, he felt different to Chris. At first, he didn't say much of anything about his "sojourn," as he called it. He would sit with Chris staring at corners of the room, smiling slightly.

He felt as if he were waiting to say something, to get up his nerve.

Chris' own feel had changed. He felt more comfortable with Jay, more curious, less defensive, less concerned with Pop. He wanted to hear what Jay had to say, but he could wait.

It took only a few meetings before Jay began to get to a few new things. "Maybe I should leave again," he said toward the end of one session.

"Couldn't blame you."

"I might get into some trouble."

"Yeah?"

With the embarrassing inevitability that seems to drive most lives, Chris had ended up in psychiatry. And now he was going to find out. Find out what this bug that had so changed his life was all about.

Chris wanted to say much more; he wanted to say they teach self-control, and all they leave is chamber music and innuendo, polite sarcasm and polished silver; the family name until it loses hold.

"I get racing and it's hard to stop. I don't know."

"Gotta go fast." Chris wanted to be vague, hoping that Jay would fill in the blanks.

"Because I blew it a long time ago. You know, Aymes, you opened the door for me."

"How?" Chris asked.

Jay sat forward with a clean-eyed look. "I'd tell you how. I'll do that because I want you to know. This stuff that you do, you don't know how long I've been listening to shrinks talk. It's a basic con game. Nobody comes clean. It's all this maneuvering. Believe me, it's enough to drive anybody nuts. But you were different, not on purpose, but you were. You're sincere, see. That makes a big, big difference, Charlie."

Chris said, "How else could I get rid of you?"

Jay's eyes lit up his dark face and he clapped his hands together. "How else could I get rid of you?"

"And get rid of this dump of a hospital."

"And get rid of this life. It sucks."

"Yeah."

"Every day, look at the tree. Remember the hospital. Remember the angiogram. They put dye in my head so they could see the vessels. My mother made them do that. She didn't like to think I was crazy. They didn't treat me like I was crazy at that hospital. This doctor took me and showed me the X-rays. He said, 'See? It's normal.' That's not what I wanted him to say. I wanted him to say that I was crazy."

"Why?"

"'Cause it would have been a lot easier. I knew what I'd done. I was mad. I was mad, mad, mad. But I wasn't crazy. Or maybe I was. How should I know. What do you do when you get so worked up you can't see straight? They teach you Anglo-Saxon types self-control at an early age, don't they."

"Yes, they do," Chris said. He wanted to say much more; he wanted to say they teach that at the expense of everything else, they teach that, and all they leave is chamber music and innuendo, all that's left is polite sarcasm and polished silver, the family name until it loses hold. He wanted to talk to Jay instead of vice-versa, but he held back, a constructive use of the self-control he so loathed.

"Well my father had it too and he

killed himself in a swamp. Burned his insides out, did you know that? Burn him up. Burn him. Burn, burn the bowels..."

"Slow down, Jay," Chris interjected.

"Ok, chief, ok. You're right. Thanks, Anglo, I needed that."

"Your father."

"You're goddam right. Who did he think he was, just pack up and leave me with her."

"Can you blame him?"

"Goddam right I can blame him. I wouldn't do that."

"No," Chris said. "What decent person would?"

"To get away from her? Maybe."

"Leave two kids?"

"Maybe. But the bastard took the easy way out."

"No guts."

"That's right," Jay began to perspire, and he wiped his forehead with his palm. "But I loved him. Why'd he give up on me?"

"He didn't want to."

"No, he didn't. He came in that night. His face is right there, right between the branches is where I put it. Him standing at the doorway. The moon hit his face and made it white. He looked at us, and walked away. I almost got up."

"But..."

"I was scared of the dark. No guts."

"You knew?"

"The bastard," Jay began to pound the chair. Little puffs of dust rose out of it.

"It won't matter if you break it," Chris said.

Jay stopped pounding. He looked at Chris, his eyes sad and blue in their dark sockets.

The two sat in silence for a few moments.

"It's time to stop," Chris said.

Jay came back the next time wanting to pick up where he had left off. Chris hadn't expected this; he had expected him to back and fill a bit, or not to want to talk about anything at all.

Spark had come into Jay's eyes. His body looked different as well: he no longer hung like draped blubber but rather sat up, hands holding the arms of the chair not to prop himself up so much as to keep himself in place.

"It got bad after he died, that's why I hate him. I'd kill him if he walked through that door right now."

"He leaves you like that, no wonder."

"I thought back to that night all the time. It just sat there in my head and wouldn't get out. She started saying he had no name in the house, if we wanted to talk about him that was up to us, but as far as she was concerned he never existed. Then she got a hold of Mulberger and it was like he really never did exist. I wouldn't have let her pull all that crap if it wasn't for David. He was really lost. He started following me everywhere. I thought it was better for us not to talk about him too much. She told me I had to be a father to him. Why, so she could go off with that guy? One night after it happened she showed me the note he wrote. And then she said, 'It's up to you now.'"

"You were supposed to take his place," Chris said.

"While she was with Mulberger I was supposed to take care of David. She said to me, 'I'm sorry, but your childhood is going to have to end now.' Then she folded up the note."

"You can see that."

"I can see the creases, her red fingernail drawing across the paper. I hated them all then, even David."

"He got off easy," Chris said.

"Look at him now, the bastard," Jay said, with pride, not anger. "I did my job with him. I became the biggest hot shot in our school, just to make him mad at me. I rubbed his face in it, and I teased him like hell. He hated me," Jay said, smiling.

"You must have loved him a lot," Chris said.

"But I hated everybody else."

"They got married."

"Then I started in with girls. My last year of high school I didn't do anything else. Harvard took me, and I took girls. I even forgot about David. By then he was hooked anyway. He was going to be a success. I kicked in a few doors, too."

"Must have felt good."

"It felt great." Chris could see Jay's mind was in a different place, his eyes alive.

Chris tried to go back with him. "In cars?"

"In cars, on the beach, in a swimming pool. . . ." But then he stopped. He put his face into his hands and he

sighed. He took his hands away and looked at Chris. "I was different then. This isn't me."

"I know."

"I want to get it back. I want to live again." He seemed almost calm.

Chris thought he could ask the question now he had wanted to ask for a long time. "Why do you stay here?"

"I don't dare leave. I could have left ten years ago, I know I could have. I could have got the doctors at Ashley to fight the commitment. But I would get crazy and I was afraid I would kill her. So I got fat and I got gross and it got harder and harder to leave. They like having me in a hospital. I just stay. This is where they want me."

"All of them."

"I didn't think I could do it out there. I was scared, Aymes."

"Who wouldn't be?"

At that moment as close to Jay's heart as Chris felt he also could touch the paradox of his own father's transformation. Over the months, but especially in the last few sessions, Jay had led Chris back through thickets of his own emotions and now Jay was showing him that it was safe, that he could let himself love and hate his father just as, in a smaller way, he loved and hated Jay, and, more, Jay was showing him that he could even feel the very stuff that was called crazy without losing balance. Jay was setting him free from his fear, even as he was trying to free Jay.

Jay heaved a long sigh.

The two sat together without speaking for a few minutes. "Thanks for some peace and quiet," Jay said.

Jay was showing him that he could let himself love and hate his father just as, in a smaller way, he loved and hated Jay—and that he could even feel the very stuff that was called crazy without losing balance.

Edward Hollowell is instructor in psychiatry at Massachusetts Mental Health Center, where he recently completed his residency. He is a graduate of Harvard College ('72) and Tulane University Medical School in New Orleans, where he began work on Second Chances. Copyright © 1985 by Edward Hollowell. All rights reserved.

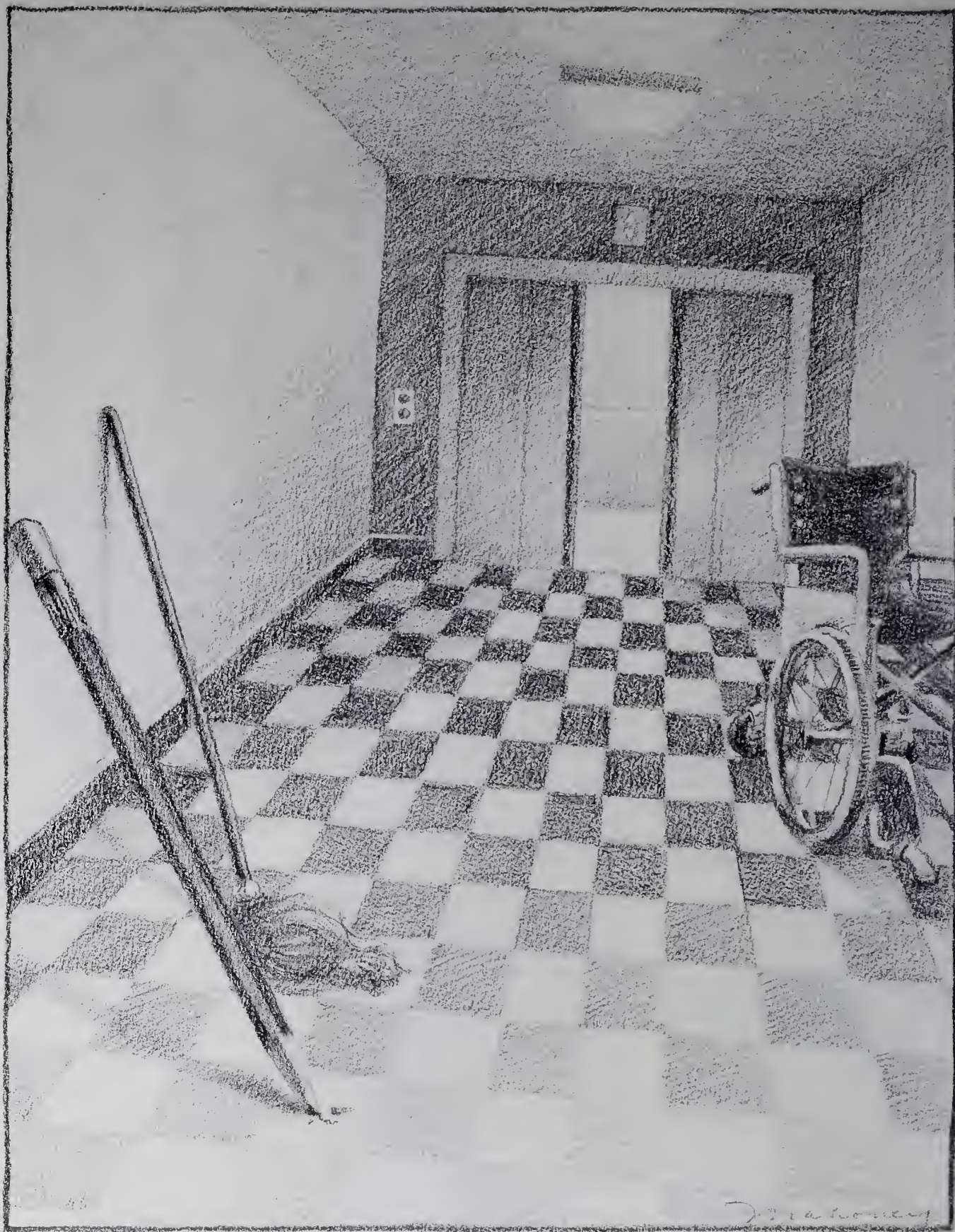


ILLUSTRATION BY KATHERINE MAHONEY

A View From Behind the Lines

by Rita Charon

Last summer 52,000 hospital workers in the New York City area—mostly orderlies, technicians, and aides (members of District 1199 of the Retail, Wholesale and Department Store Union, AFL-CIO)—protested a contract dispute with a seven-week strike that ultimately affected 29 hospitals. By the time it was over, eight hospitals had been cited for deficiencies caused by the strike; nurses had walked out in sympathy at five hospitals; violence by picketers had erupted at some of the sites; health benefits to the strikers had been cut off; and Governor Cuomo had intervened to request the resumption of broken-off negotiations, and to ask the state health commissioner, David Axelrod (HMS '60), to stand by the talks to offer technical assistance.

Within the hospitals, whether sympathetic to the strikers or not, physicians, remaining staff, and volunteers made do. In the following piece, Rita Charon '78, a general internist on the faculty of the Division of General Medicine at Columbia-Presbyterian Medical Center, shares her impressions of the strike from the perspective of one caught in the middle.

The 1199 strike at Presbyterian Hospital will long be remembered for the malaise it engendered, the wedges it drove between professional and non-professional staff, and the clarity it shone on some of the true goals and priorities of the institution. The strike was not a time of passionate anger or jubilant victory. It was instead a time of blunted affect, uncertainty, and universal blame. Ultimately, it only blurred the complex questions it brought to the surface about health care in the city.

The hospital was frightfully quiet. Elevators that one generally has to enter with a shove and an excuse were now empty and express. All clinics were closed. Faculty group practices in medicine, pediatrics, and OB-GYN, all of which serve mainly poor patients, were shut down initially. The private doctors' offices were not affected by the strike; patients with means continued to get ambulatory care. All in-patient services continued to operate as usual, with an 80 to 90 percent occupancy throughout the strike. Elective admissions, surgery, and procedures were not affected.

People who had dealt with patients in terms of administrative tallies and budgetary decision-making were now face-to-face with them.

In-patient wards, the Emergency Room, and walk-in areas were staffed by nurses (they weren't 1199 and didn't walk out), attending physicians and house staff, and managerial staff assigned to duties at 12-hour, six-day-per-week shifts at time-and-a-half. These administrative and managerial personnel covered duties of 1199 clerical staff, orderlies, housekeepers, food service personnel, and receptionists. Three-piece suits and executive suite dresses were replaced by blue scrubs.

People who for years had dealt with patients in terms of administrative tallies and budgetary decision-making were now face-to-face with them: answerable to them, sizing them up, ultimately dressing them down. Administrators who started out the strike with generosity and a true wish to be of service to patients ended up wishing never to see another patient again. Such was the current of the strike.

During the first part of the walk-out, there seemed to be a reasonable number of picketers on the line, although it was always hard to judge because the multiple entrances to the medical center split the members into insignificant-appearing lines. They stayed obediently behind the royal blue NYPD sawhorses, listlessly chanting "No Contract, No Work" to the beat of screwdriver against hubcap or spoon against skillet. The picket lines were overwhelmingly non-white and female, a fact that stunned even those of us who realize the racial and sex profiles of hospital workers.

A naive third-year medical student reported to me that work was going on as usual on the wards because members of another union had come in to replace the members of 1199. I could make no sense of this until he told me the local number of the

generous union: Local 1200. The administrative personnel taking over for the strikers wore caps and t-shirts emblazoned with the legend "Local 1200: A Cut Above the Rest." I don't know how many besides this student failed to see the jest and the malice of this game. A newsletter circulated several times a week from this "Local 1200" reporting funny experiences of senior administrators as they dished out food in the cafeteria, or of erstwhile administrative aides as they competed in gurney-pushing races. Despite its poor taste, the rabid undercutting of 1199 worked to whip up enthusiasm and elan among the managerial staff. There was at least for the first half of the strike a sense of joviality under fire, sweetened by dreams of trips to be taken with all the bonus pay.

Meanwhile, despite my student's perception, things were not going on as usual on the wards. Medical students on their medicine rotation pushed stretchers, drew and ran all bloods, stocked supply rooms. They picked up the slack to the detriment of their education in medicine; I hesitate to guess what they learned about labor struggles during this time. Many services were unavailable: labs ran only limited tests (if you wanted a diff, you counted it yourself), social services were provided by a few supervisors covering their striking workers, and discharge planning was difficult because no follow-up ambulatory visits could be scheduled.

There was a contradiction on the experiential level for house staff and students: they were forced to do much more scut, but they perceived that things were running more smoothly than usual. Several explanations offer themselves. The initial blush of enthusiasm of the managerial staff may have led to more verve in dispatching the duties of ward clerk or transport worker. This intensified effort reflected badly on the remembered per-

formance of 1199 workers, who were judged harshly in comparison. House staff and students, as part of the effort to best the strike, had a stake in maintaining the status quo. The net impression was that the hospital ran just as well without 1199 as with it.

Things changed outside after the first payday went by without a check. It became known that 1199 had no strike fund (undocumented rumor had it that the strike fund had been unwisely invested), and that strikers had to support themselves for the duration of the strike. These are not, we said to each other, people with liquid savings. These paychecks are not, by and large, elective second salaries for households. How will my receptionist pay her rent and buy clothes for her kids to wear back to school?

The absence of paychecks changed the tenor of the picket line as well. Catcalls of "scab" increasingly accompanied employees into the hospital. A few tires were slashed. To the credit of the union, there was no true violence. Some physicians, to the dismay of their departments, joined the picket line. Individual workers bemoaned the length of the strike and voiced the wish to return to work with or without 1199; none at Presbyterian did so, although this happened at other institutions in the city. The resolve of the strikers in the face of their financial distress was impressive. They were convinced that the struggle was worth engaging, and they made do with pick-up work and help from friends. Another contradictory complex of feelings toward 1199 emerged: were they leading their workers in a futile and poorly planned gesture without the necessary financial support, or were they in fact the workers' voice and source of power?

There was a distinct shift mid-strike. By the fourth week, there

The ambulatory patients waiting at home without their medicines or physical therapy were the unsung participants and forgotten victims of the strike.

appeared a silent invasion of 18-year-old kids with temporary ID cards. They donned scrub suits and mopped floors, carried trays, pushed stretchers, and transported specimens. Where they came from no one knew; where they found the gumption to scab so openly was beyond us. They gained access to the hospital via tunnels from the administrative building, thereby escaping the wrath of the picketers. Their presence was a boon and a respite to the managerial staff, who lightened their load to a five-day week. The arrival of these young strike-breakers was for the strikers a serious omen: it raised the possibility that the hospitals might break the union altogether.

Throughout the walk-out, *The New York Times* routinely referred to the "52,000 workers and 17,000 patients affected by the strike." Those numbers reflected only in-patients, and on a deeper level reflected the priorities of the hospitals. Administration could brag to the press that they were making three-quarters of a million dollars for each week the strike continued. This bonanza was in large part caused by the continuance of income-generating services of the hospital—mainly in-patient care—and closure of money-losing parts of the hospital, such as clinics for poor patients.

The objective correlative of that savings piled up in doctors' mailboxes each day. Pink "While You Were Out" memos declared, "Mrs. Jonas panicked. Call right away," or, "Mrs. Montana needs M11Q, will lose homemaker if not signed today," or, "Mr. Dagostino ran out of insulin. What should he do?" These out-patients were marooned by the strike and by the priorities set by the hospitals in response to it. I, as their primary care doctor, felt marooned from them. Where in that 17,000 were my ambu-

latory patients waiting at home without their medicines, without their physical therapy, without their out-patient work-ups of chronic problems? These patients at home were the unsung participants and forgotten victims of the strike. Many of them were generic allies of the workers, and understood the importance of this event on a deeper level than did the professional staff.

The hospital not only serves hidden populations, but serves them in hidden ways. Mrs. Jonas is a 48-year-old severely depressed woman who displays remarkable strengths in dealing with her house full of grown and demanding children. She has made several serious suicide gestures in the past, but had been doing well with frequent visits to me and the social worker on my unit. When I called, she said, "I didn't feel there was anyone I could turn to if I needed help. It's not like something had happened, but I felt all alone that I couldn't come in to see you if I had to, and that made me crazy."

Mrs. Montana is a 35-year-old woman with spastic cerebral palsy and recent post-hepatic Reiter's syndrome who can't function without her home health attendant to help with her three young children. To lose that social service would have been tantamount to a major medical emergency. Mr. Dagostino is a 46-year-old Type I diabetic with a character disorder with paranoid features who is afraid of insulin. The interference in the care of these patients will take a long time to repair. The true malevolence of the strike was that these effects were selective, affecting poor patients, and unnoted by either press or administration.

Late in the strike, my faculty group practice and the others elected to reopen on a limited basis to see sick patients and those, like newborns, who needed regular health promotion visits. This move to reopen was made

with the greatest ambivalence, by practitioners who wanted neither to undermine the union nor neglect patients who needed attention. We received support from the departments and the administration to resume services; we received the retrospective support of 1199 workers in our areas who agreed that our decision to partially reopen was sound and not antagonistic to the strike.

After seven weeks, the negotiations wound toward an acceptable settlement. Workers returned to their jobs with a minimum of fanfare. The 18-year-olds disappeared as quickly as they had appeared. There have been retributions, such as reassignment of workers to foreign territory—in some cases (such as for social workers) with drastic interference in patient care. Medical students are back to reading the literature; administrators are back in pinstripes. Clinics are overwhelmed with backlog, and will be for some time.

□ □ □

I stepped with difficulty onto the clinic building elevator. I had to crowd between two wheelchairs and a stroller. Mrs. Greengrass, the 1199 elevator operator, flatly called out floors and directed passengers to step in and make room. Her elevator is automatic; the door movement is in no way regulated by the "open door" and "close door" buttons on the control panel. I watched through her eyes as weary patients stumbled on and off her conveyance, as shabbily dressed passengers clutched clinic appointment slips, wheezing and rheuming with the effort of getting to their destinations. At every stop, Mrs. Greengrass diligently beat on the ineffective door control buttons. Neither she nor the rest of us have any more control than ever.



Samuel Robinson during World War I, 1917, in his San Francisco years.

Sam Robinson's Box

by Gordon Scannell

THIS IS THE STORY OF A gadget and the man who put it together. Really more than a gadget, Sam Robinson's box was part of technical progress that allowed surgeons to operate safely within the open chest. In this field, the big name, of course, is Sauerbruch. His negative pressure chamber is generally well known—at least among thoracic surgeons. Modifications of his chamber were brought to New York and widely publicized. But few, even in Boston, know about Sam Robinson and his box here at Harvard.

Samuel Robinson was born in Augusta, Maine, in 1875. A graduate of Harvard College and Harvard Medical School ('02), he served two years as a surgical house pupil at Massachusetts General Hospital. In 1904 he was appointed to the MGH staff as surgeon to outpatients, the lowest rung on the ladder. In addition to his clinical work at the hospital, he worked at the medical school in the Department of Physiology with his contemporary Walter Cannon, already well embarked on his brilliant career.

Following the custom of the day, Robinson supported himself as assistant to Charles Allen Porter, a surgeon of ability, distinction, and elegance, a friend of John Singer Sargent. Robinson's clinical ability soon caught the eye of J. Collins Warren who, in 1908, arranged that he study a year with Brauer and Sauerbruch in Germany.

Sauerbruch had been assistant to von Mikulicz, whose pioneer role in thoracic surgery—graphically described by Eloesser in "Milestones in Chest Surgery" (*Journal of Thoracic and Cardiovascular Surgery*, Volume 60, 1970)—has been enshadowed by his contributions to the surgery of the alimentary tract. Von Mikulicz recognized that the key to surgery of the chest was the use of differential pressures to permit adequate ventilation during operations within the thorax. The assistants in his department worked intensely on the problems of negative and positive pressures.

Of the two options, Sauerbruch, a pioneer in both, chose the negative pressure route and developed a chamber which became widely known and clinically used. Willy Meyer, a pioneer thoracic surgeon in New York, had two Sauerbruch chambers built, one at Rockefeller Institute and one at

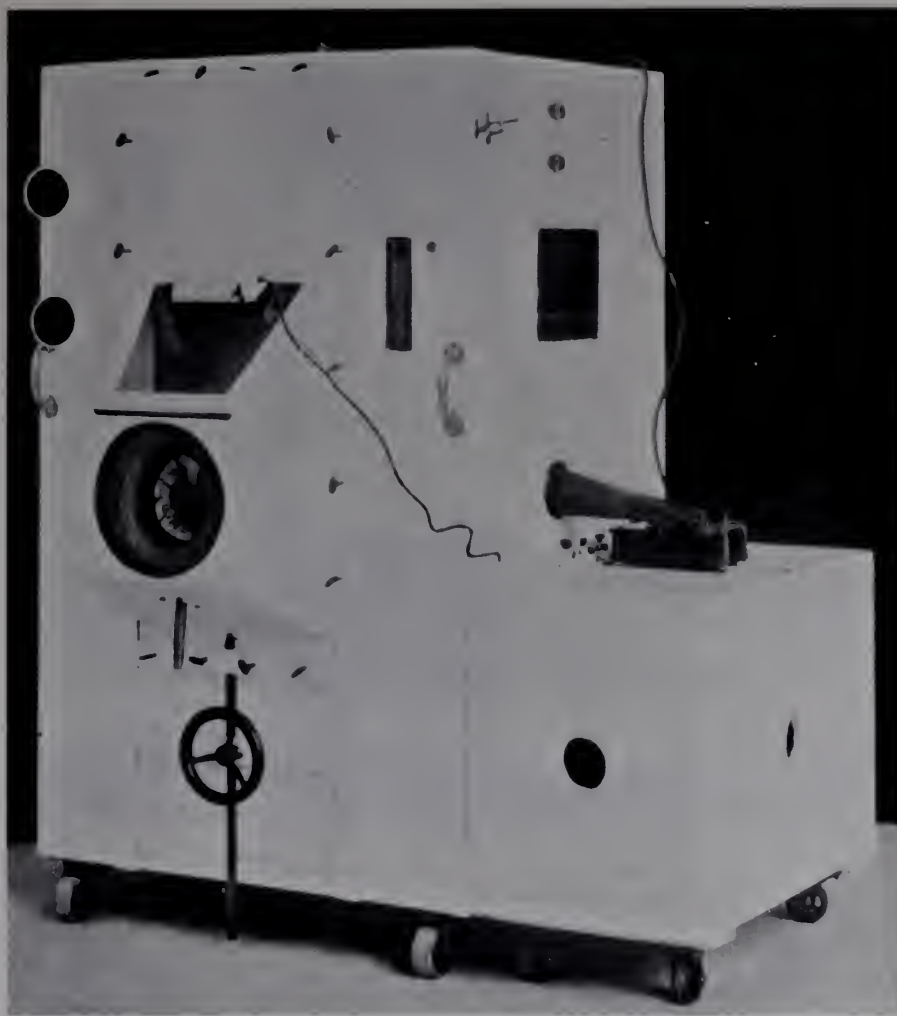


Figure 1. Positive pressure cabinet and pump box, front view: metallic hood with window and electric light, double rubber collar, mechanism for raising and lowering hood, megaphones, manometer window.



Figure 2. Left and back walls of cabinet. Pump box disconnected. Outer door of air lock open. Outer arms of refrigerator locks.

Since this was MGH, ether was the popular agent; the possibility of an electric spark with ether under pressure defies the imagination.

illustrated with the photographs included on these pages.

Robinson returned to Boston and to his clinical appointment at MGH in 1909. He promptly set about building his positive pressure chamber. Within a year he could report: "In a series of twenty-three such operations (thoracic cases) by me in the past year I have been much impressed by the anesthesia administered by Dr. Freeman Allen, who has used ether, chloroform, anesthol and other mixtures with and without oxygen, interchangeably as the condition of the patient seemed to indicate. The patients have left the operating table without evidence of excess or ill applied anesthesia, and of the four fatalities in this group, none could be credited to the narcosis."

German Hospital in New York.

The "negative pressure" chamber was large enough to accommodate the patient and the entire operating staff. Only the patient's head stuck out to allow anesthesia at atmospheric pressure. In his early publications Sauerbruch considered the merits of enclosing the patient's head and the anesthetist in a positive pressure chamber, with the rest of the patient outside where the operating team would have ready access. Brauer acted on this suggestion, and, with his associate Peterson, constructed a suitable apparatus. From it Robinson derived his box, described with loving detail in "A Positive Pressure Cabinet for Thoracic Surgery" (*Surgery, Gynecology and Obstetrics*, Volume X, 1910)—il-

A frontal view of Robinson's box, constructed at the surprisingly low cost of \$300, is shown in Figure 1. Protruding from the front was a four-sided hood with a window in the sloping upper wall through which a light shined (shades of the prophet Isaiah) upon the patient's face. The purpose of this hood was to allow elbow room for the operating surgeon and his assistant (outside the chamber, of course). The level of the hood, which was riveted to a metal slide, could be adjusted by a wooden wheel and a rack and pinion gear. The hole in the hood for the insertion of the patient's head was lined with a rubber collar elastic enough to permit entrance of the head, yet firm enough to resist pressure in the cabinet with-

In the year or so the box was in use, Robinson did all his thoracic cases with the patient's head in the chamber whether the pressure was needed or not.

out ballooning. There was a purse string that could be drawn closely about the neck to reduce the amount of leakage without materially changing the pressure within the cabin.

Through a glass window on the front one could read the water manometer on the inside and arrive at some estimate of the differential pressure. The anesthetist could read the same manometer. On the right side of the hood were two small megaphones, one connected with air tight ear caps worn by the anesthetist (Figure 3), and the other with a speaking tube mask seen in the view of the interior of the chamber. Communications, therefore, between the operator and the anesthetist could be regulated as the occasion demanded. Figure 3 also shows Allen, the anesthetist, ready for action.

Figure 2 shows a window with an air lock in the upper portion of the wall of the cabin through which ether bottles, esophageal sounds, and any other paraphernalia could be passed to the anesthetist. In the center of this left wall, at the level of the top of the pump box, there was a hole around which was riveted a large heavy rubber glove. By inserting his hand in this glove, the etherizer could regulate the switches and rheostats on the top of the pump box (Figures 2 and 3). The object of this arrangement was to remove from within the cabinet all possible electric sparks which might ignite ether fumes. Needless to say, since this was MGH, ether was the popular agent and the possibility of an electric spark with ether under



Figure 3. Anesthetist seated in cabinet with door open. Hand on regulation of escape valve. Ear piece in position. Rubber glove lying over cover to pump box. Note rheostat and switches.

pressure defies the imagination. Apparently no such accident happened.

Control of the pumps and, therefore, the pressure within the cabinet, was a responsibility of the anesthetist—but if the etherizer was entirely unfamiliar with the mechanism, the whole apparatus could be controlled from without. At least this setup preserved the illusion that the surgeon was in command of the situation.

There was an escape valve from the cabinet that allowed the exhaled carbon dioxide of the patient and of the anesthetist to be disposed of with the ether fumes. Robinson pointed out that there had not been the slightest sensation of ether or chloroform effect on any anesthetist who had operated within the cabin.

Both the operating surgeon and the etherizer could vary the pressure within the cabinet. In Figure 3 the etherizer's right hand rests on an inside lever. Robinson found it most convenient to tell the anesthetist at different stages of the operation how much water pressure was necessary. It was Allen's custom to keep the

pumps running at low speed with the escape valve wide open when no pressure was needed. In this way he provided ideal ventilation of the cabinet to his advantage and to that of the patient.

The essentials of the inside of the chamber are shown in Figures 3 and 4. There was room enough inside for two people to sit, although usually only one did so. Robinson avoided the use of electric telephone communications for two reasons. First, he thought the pressure of the chamber would interfere with the motion of the diaphragm in the instrument. Second, electric telephones at that time had "complications." A speaking tube was foolproof except for pressure on the ear drums, similar to what we feel as the cabin of an airliner is compressed or decompressed.

Robinson described the details of the pumps, which were of a large volume variety. One wire connection between the pump box and a neighboring lamp socket was all that was required to activate the pumps. The cost of the complete apparatus was

in the neighborhood of \$300. In the year or year and a half that the box was in use, Robinson did all his thoracic cases with the patient's head within the chamber whether the pressure was needed or not. The operation and anesthesia, therefore, could be carried on in the usual way but at any indicated moment pressure applied.

Without the help of a Human Studies Committee, Robinson was enough of a clinical scientist to test in alternate cases another form of anesthesia while testing the positive pressure box method. Quite early he discovered the usefulness of intra-tracheal anesthesia and described at length a method that relied upon

insufflation, or positive pressure with a face mask. He did not arrive at the point of balloon occlusion of the trachea. He found the intra-tracheal method not only easier, but equally effective—and therefore, as a concession to convenience, the box was abandoned.

There are very few references to this box in the literature. There is also no trace of the box to be found at the present time at MGH.

Sam Robinson remained at MGH until 1912, the year he published, with his associate Cleveland Floyd, "Artificial Pneumothorax as a Treatment of Pulmonary Tuberculosis" in *Archives of Internal Medicine*. Although he had done a great many experi-

mental resections in Sauerbruch's lab and also on his return to Boston, he was much more than a rabbit and dog surgeon. In 1909 he did his first lobectomy for bronchiectasis. This was a two-stage procedure, a far cry from present day techniques, but nonetheless an important contribution. With an unusual disregard for priorities, he did not report this case until 1916, after he had added five more, done at the Mayo Clinic.

Sam Robinson left Boston in 1912. He joined a former Boston surgeon, James Mumford, at Clifton Springs Sanitarium in New York. After Mumford died in 1914, Robinson went on to the Mayo Clinic to be chief of thoracic surgery from 1915 to 1917; thence to San Francisco during the War; and, finally, to Santa Barbara, where he lived and practiced until his death in 1947.

Sam Robinson was a founding member of the American Association for Thoracic Surgery; in 1923 he was elected president. That same year, in his 25th Harvard Reunion Report, he made it clear why he left the teaching institutions with which he had been associated. In 1917, after a prolonged bout of pneumonia that had seriously limited his military service, he had moved to Santa Barbara in search of a climate that might prevent the frequent attacks of bronchitis and pneumonia that had plagued him in the East. With a note of regret he writes, "In practicing surgery now in a small community I am resigning all hopes of distinction in my profession. Better health is my consolation however."

The box was only one of Robinson's many contributions. He was a pioneer in the management of bronchiectasis and wrote sensitively of the psychological as well as the surgical aspects of the disease. He was a pioneer in collapse therapy for tuberculosis and with Floyd wrote a superb paper on the subject of artificial pneumothorax and the treatment of this disease. The essay is a model of clinical reporting—a graphic account of the devastating effects of tuberculosis in young patients.

Sam Robinson's box is long forgotten, but let us include him in the band of famous men we praise: "Leaders of the people by their counsels, and by their knowledge of learning meet for the people; wise and eloquent in their instructions..."

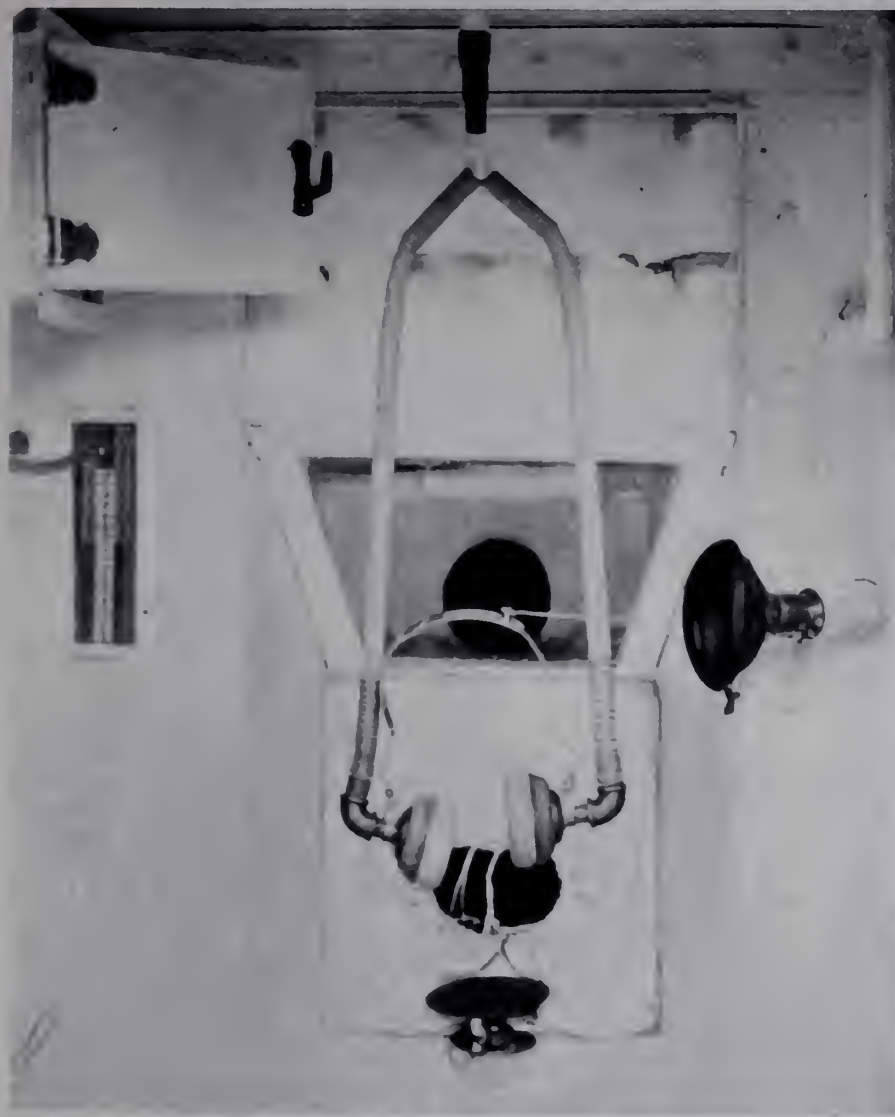


Figure 4. Front wall of cabinet from the interior. Inner door of air lock open. Shows speaking tube system. Water manometer. Head rest (not padded), inner thin rubber collar with purse string.



Jimmy on Easter Sunday, 1983.

The Homeless

Photographs by Jerry Berndt

The photographs on these pages are selected from an exhibit at Countway Library sponsored by the Harvard Public Interest Health Foundation, a student organization interested in the improvement of the health status of the medically disadvantaged.

Boston photojournalist Jerry Berndt began this project at the inception of Long Island Shelter for the Homeless in Boston Harbor in the winter of 1982. An emergency measure, the shelter was slated to close with the arrival of spring. Berndt's photographs, used in a presentation to Boston City Council in May 1982, were instrumental in keeping the shelter open. This winter the facility, which originally slept 100, is expanding to 350 beds.

In a study on poverty in New England, J. Larry Brown of Harvard School of Public Health concluded in Febru-

ary 1984, "If stated in medical terms, the hunger we saw exists in epidemic proportions." He found that 20,000 people were served by food programs in the Boston area in January 1983 alone.

"I began photographing the homeless," Berndt tells us, "in an attempt to understand who they are, to put a face on the problem—to remind myself and others that, in the midst of all the data and statistics, we are dealing with people and their lives. On the coldest nights in 1983 more Americans slept in shelters for the homeless than in any winter since the Great Depression. I wanted to break through the emotional and intellectual barriers we all erect to shut out unpleasantness and misfortune—and I have tried to use photography to create an empathic connection between those who effect

public policy concerning the homeless, and the people themselves." The photos here are all from Long Island Shelter.

Berndt's skills have often been employed by the *Bulletin*; his work can be seen elsewhere in this issue. His work also appears in *The Boston Globe*, *Newsweek*, *Time*, *Scientific American*, and other publications.

The HPIHF was founded in 1981. It has given grants to promote community health education and promotion, including a recent organizational grant for the Urban Student Health Project. A recently formed student group, the USHP hopes to place HMS students in health programs in underserved Boston neighborhoods for the summer between their first and second years.



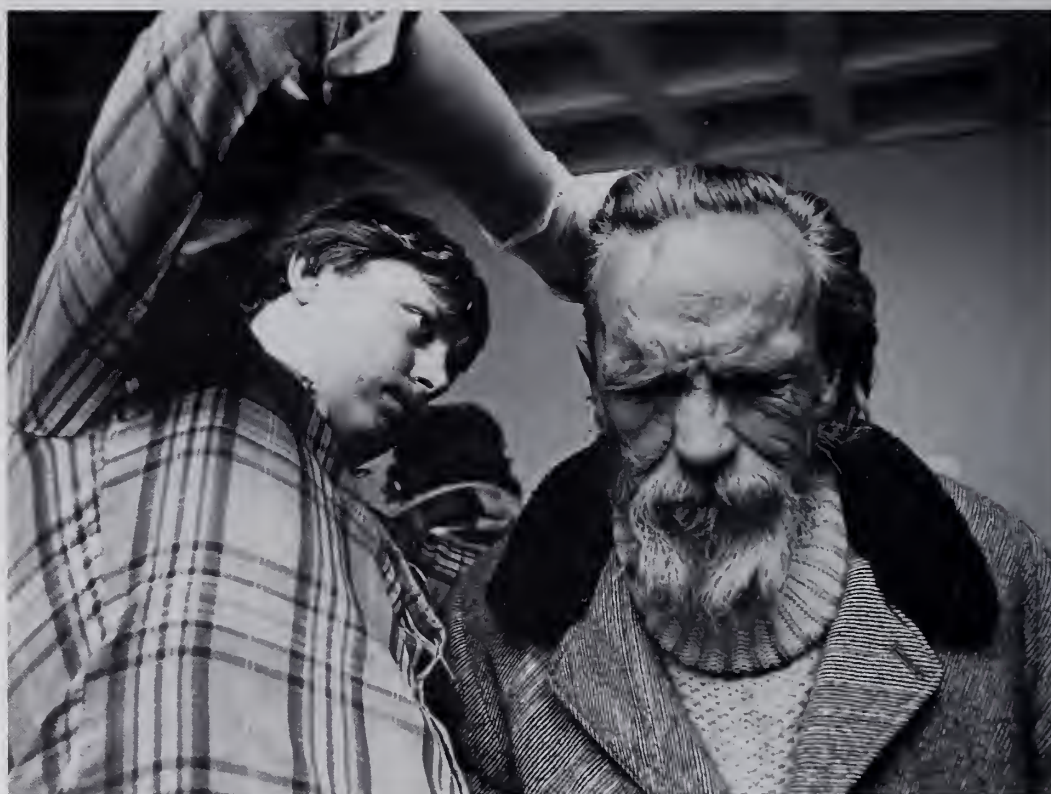
Check-in, February 1983.



Above: Janet's husband died, she lost her apartment, and slept on the Cambridge Common on a February night. Frostbite, 1983. Left: He brought his family up from Georgia, looking for work and a good education for the kids. Their money ran out and they were found sleeping in the subway, 1984.



Olga—raped and her face set on fire, March 1983.



Checking for lice, 1983.



Noreen, the night nurse, 1983.



Her daughter in a foster home, Mother's Day, 1983.



The Travel Program Of Alumni Flights Abroad



This is a private travel program especially planned for the alumni of Harvard, Yale, Princeton and certain other distinguished universities. Designed for the educated and intelligent traveler, it is specifically planned for the person who might normally prefer to travel independently, visiting distant lands and regions where it is advantageous to travel as a group. The itineraries follow a carefully planned pace which offers a more comprehensive and rewarding manner of travel, and the programs include great civilizations, beautiful scenery and important sights in diverse and interesting portions of the world:

TREASURES OF ANTIQUITY: The treasures of classical antiquity in Greece and Asia Minor and the Aegean Isles, from the actual ruins of Troy and the capital of the Hittites at Hattusas to the great city-states such as Athens and Sparta and to cities conquered by Alexander the Great (16 to 38 days). **VALLEY OF THE NILE:** An unusually careful survey of ancient Egypt that unfolds the art, the history and the achievements of one of the most remarkable civilizations the world has ever known (19 days). **MEDITERRANEAN ODYSSEY:** The sites of antiquity in the western Mediterranean, from Carthage and the Roman cities of North Africa to the surprising ancient Greek ruins on the island of Sicily, together with the island of Malta (23 days).

EXPEDITION TO NEW GUINEA: The primitive stone-age culture of Papua-New Guinea, from the spectacular Highlands to the tribes of the Sepik River and the Karawari, as well as the Baining tribes on the island of New Britain (22 days). The **SOUTH PACIFIC:** a magnificent journey through the "down under" world of New Zealand and Australia, including the Southern Alps, the New Zealand Fiords, Tasmania, the Great Barrier Reef, the Australian Outback, and a host of other sights. 28 days, plus optional visits to South Seas islands such as Fiji and Tahiti.

INDIA, CENTRAL ASIA AND THE HIMALAYAS: The romantic world of the Moghul Empire and a far-reaching group of sights, ranging from the Khyber Pass and the Taj Mahal to lavish forts and palaces and the snow-capped Himalayas of Kashmir and Nepal (26 or 31 days). **SOUTH OF BOMBAY:** The unique and different world of south India and Sri Lanka (Ceylon) that offers ancient civilizations and works of art, palaces and celebrated temples, historic cities, and magnificent beaches and lush tropical lagoons and canals (23 or 31 days).

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